

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12A

08006 141

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Frederick  
 County .....  
 City or town ..... Brunswick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 32 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State ..... Maryland County ..... Frederick  
 City or town ..... Brunswick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ..... 403 No. Maple Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

3. (a) FULL NAME  
 HARMON L. AHALT  
 4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced  
 Widowed  
 6.(b) Name of husband or wife Anna M. Fyler  
 7. Birth date of deceased (mo., day, yr.) Dec. 7th. 1871  
 8. AGE: Years 73 Months 8 Days 4 If less than one day  
 hrs. ..... min.  
 9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business  
 12. Name Jhousa D. Ahalt  
 FATHER  
 13. Birthplace Maryland  
 MOTHER  
 14. Maiden name Laura Shaf'er  
 15. Birthplace Maryland  
 16. Informant Mehrl E. Ahalt  
 Address Brunswick, Maryland.  
 17. Burial Date thereof 8-14-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Lutheran Cemetery  
 Location Middletown, Maryland  
 18. Funeral director C. H. Fette and Bro.  
 Address Brunswick, Maryland

19. Aug. 14- 1945  
 (Date rec'd by registrar) *Emilia Martin*  
 (Signature) *Dep. Registrar*

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1945 et 13 A M  
 21. I CERTIFY that death occurred on the date above stated, that I attended deceased from  
 July 15 1945 to Aug 11 1945 and that I last saw him alive on Aug 7 1945  
 Immediate cause of death *Cardiac Arrest*  
 Due to *Hypertension*  
 Due to *Hypertension*  
 Other conditions *Age*  
 (Include pregnancy within 8 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur? ..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (Where?)  
 Means of Injury Injured at work?  
 23. SIGNATURE *Dr. Harmon E. Ahalt*  
 M. D. or other  
 Address ..... Date signed 8/13/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

68907

## CERTIFICATE OF DEATH

Reg. Dist. No. 144

## 1. PLACE OF DEATH:

County FrederickCity or town Thurmont

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary A. Albaugh4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Maurice J. Albaugh7. Birth date of deceased (mo., day, yr.) July 2, 1875 8. (c) If alive, give age 85 years8. AGE: Years 70 Months 1 Days 21 If less than one day  
hrs. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Housework

## 11. Industry or business

12. Name Charles C. Currens13. Birthplace Maryland14. Maiden name Amanda Shaffer15. Birthplace Maryland16. Informant Mr. Maurice J. AlbaughAddress Thurmont, Maryland17. Burial Burial Date thereof August 25, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory United Brethren CemeteryLocation Thurmont, Maryland18. Funeral director C. O. Fuss & SonAddress Taneytown, Md.19. Aug 24 1945 (Date rec'd by registrar)19. Aug 24 1945 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Thurmont (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (b) Social Security Number  
none

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1945 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 1945 to August 23 1945 and that I last saw her alive on August 22 1945

Immediate cause of death

Decineza of the Heart DURATION 1 year

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE James GrayM. D. or other MDAddress Thurmont, Md. Date signed 8/23/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

08908

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:  
County..... Frederick  
City or town..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 25 years

Hospital, Institution, or street address where death occurred:

179 West All Saint Street

How long in hospital or institution?.....

3. (a) FULL NAME

JAMES SABROSIA AMBUSH

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	C	S

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) January 20, 1897

6. (c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
48	7	1	hrs. min.

B. Birthplace..... Tuscarora-Frederick-Maryland  
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business.....

12. Name..... Joseph R. Ambush

13. Birthplace..... Frederick County Maryland

14. Maiden name..... Agnes Barton

15. Birthplace..... Frederick County Maryland

16. Informant..... Mrs. Agnes B. Ambush

Address..... 179 W. All Saint St., Fred'k, Md.

17. Burial..... Date thereof..... 8/24/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Fairview Cemetery

Location..... Frederick, Maryland

18. Funeral director..... M. R. Etchison and Son

Address..... Frederick, Maryland

19. Date reg'd by registrar..... 8/22/45  
Registrar..... Elizabeth Neale

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Frederick

City or town..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 179 West All Saint Street

(If rural, give LOCATION)

2.(a) If veteran, name war..... World War I

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 21st, 1945, at 4:45P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 20, 1945, to August 21, 1945  
end that I last saw him alive on August 21, 1945

Immediate cause of death.....

Coronary Occlusion  
Chronic Myocarditis

DURATION

77

Due to.....

Due to.....

Severe Gastric-Extrophy 10 days  
with strangulated Hernorrhoids

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of Injury.....

Injured at work?

23. SIGNATURE..... Howard W. Ash

M. D.

M. D. or other

Address..... Frederick, Maryland Date signed 8-22-45

A rectangular stamp with a double-line border. The text "FBI LABORATORY" is at the top, "AUG 24 1945" is in the center, and "BUREAU 4-8" is at the bottom.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08909

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:  
County Frederick  
City or town Frederick-Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Emergency Hospital  
How long in hospital or institution? 22 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Frederick  
City or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 144 East South Street  
(If rural, give LOCATION) None

2.(a) If veteran, name war.....

3. (a) FULL NAME  
JAMES HENRY BARNES

3. (b) Social Security Number  
None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced— W

8. (b) Name of husband or wife Emma Steele

7. Birth date of deceased (mo., day, yr.) March 31, 1871 8. (c) If alive, give age ..... years

8. AGE: Years 74 Months 4 Days 21 If less than one day hrs. ..... min.

9. Birthplace Ellicott City-Howard-Maryland  
(Town, county, and state)

10. Usual occupation None

11. Industry or business  
FATHER 12. Name Unknown

MOTHER 13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mr. Ralph J. Beacht

Address 144 E. South St., Frederick, Md.

17. Burial Date thereof 8/24/45  
(Burial, cremation, or removal. Which? (month) (day) (year))

Cemetery or place Union Chapel Cemetery

Location Near Liberytown, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. Aug. 23 1945 Elizabeth G. Deck  
(Date rec'd by registrar) F.M.H. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1945 at 5:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 1 1945 to Aug. 22 1945  
end that I last saw him alive on Aug. 21 1945

Immediate cause of death.....

Cardiac Decompenation

Due to Ch Cardiac Muscular Dystrophy

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

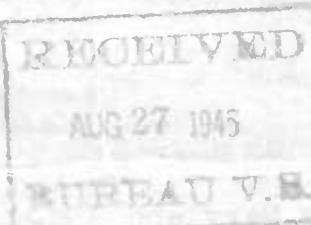
Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE H. Lawrence Fahney M. D.

M. D. or other

Address Frederick, Maryland Date signed 8-22-45



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

40

## CERTIFICATE OF DEATH

08910

131



Reg. Dist. No.

1. PLACE OF DEATH:  
Frederick  
County

City or town  
Frederick

(If outside city or town limits, write RURAL and give nearest town)

8 Days

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Frederick City HospitalHow long in hospital or institution?  
8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Tuscarora - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Licksville

(If rural, give LOCATION)

2.(a) If veteran, name war  
None

## 3. (a) FULL NAME

ALICE LILLIAN BELL

4. Sex F	5. Color or race W	6.(a) Single, married, widowed, or divorced S
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6.(b) Name of husband or wife.....

7. Birth date of  
deceased (mo., day, yr.) October 19, 1873

8. AGE: Years 71	Months 10	Days 10	If less than one day hrs. .... min.
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9. Birthplace  
Pittsburgh, Pa.  
(Town, county, and state)10. Usual occupation  
At Home11. Industry or business  
Samuel H. Bell

MOTHER FATHER	12. Name Paris, Pa.
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MOTHER	13. Birthplace Ann Frances Robinson
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MOTHER	14. Maiden name Ireland
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MOTHER	15. Birthplace Miss Mary B. Bell
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16. Informant Address	Tuscarora, Maryland
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17. Burial (Burial, exhumation, or removal. Which?)	Date thereof 9/1/45 (month) (day) (year)
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Cemetery or columbarium Location	Mount Olivet Cemetery Frederick, Maryland
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18. Funeral director Address	M. R. Etchison and Son Frederick, Maryland
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19. 30 - Aug 19 45 (Date rec'd by registrar)	Elizabeth G. Heck Registrar
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## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH  
August 29th, 1945, at 5:15P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 1943, to Aug 29 1945  
and that I last saw her alive on Aug 29 1945.Immediate cause of death  
Coronary Artery Disease with  
Myocarditis.DURATION  
P

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE  
Howard W. Ash M. D.

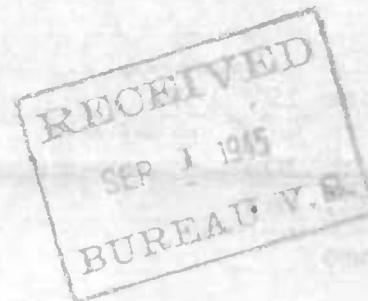
M. D. or other

Address..... Frederick, Maryland Date signed..... 8-30-45

ПЪЛЕН ВЪЗМОЖНОСТ СТАВА НАМ

СЪДЪРЖАНИЕТО СЕ ПОДДЪРЖА

ПЪЛЕН ВЪЗМОЖНОСТ



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

08011

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County

City

Frederick  
Frederick Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred

Frederick Hospital  
18 days

How long in hospital or institution

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race.

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Samuel Butler Bennett

7. Birth date of deceased (mo., day, yr.)

November 2, 1866

8. AGE:

Years

Months

Days

If less than one day

79

9

3

hrs.

min.

9. Birthplace

(Town, county, and state)

Frederick, Frederick Co., Maryland

Hometown

10. Usual occupation

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

5. Color or race.

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

11. Industry or business

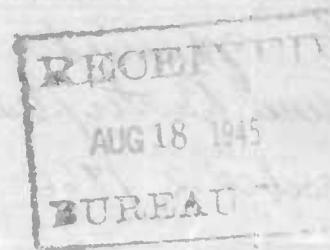
12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden name



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

08012

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County

City or town

Frederick Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred

Emergency Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Baby Boy Blackston

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

S.

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

August 28, 1945

8. (c) If alive, give age

years

8. AGE:

Years

Months

Days

Less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

18. Informant

Address

17. Burial

(Burial, cremation, or removal, which)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 529 Rehbergs Alley

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 28, 1945, at 11:00 M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from

August 28, 1945, to

and that I last saw him alive on

Immediate cause of death

Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

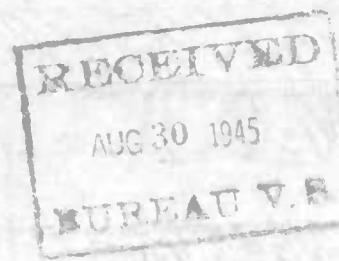
Injured at work?

23. SIGNATURE

J. E. Harp, M.D.

M. D. or other

Address: Middle Street Date signed: 8-29-45



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

68-1313  
Reg. Dist. No. 1

1. PLACE OF DEATH: Frederick  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Lifetime  
Now long in above place of death?  
Hospital, Institution, or street address where death occurred:  
235 East Church Street  
Now long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland.....  
County Frederick  
City or town.....  
Frederick  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 235 East Church Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....  
None

## 3. (a) FULL NAME

GUY BLACKSTON

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married
6. (b) Name of husband or wife..... Bertha Edmonds		
6. (c) If alive, give age..... 66 years		
7. Birth date of deceased (mo., day, yr.) August 31-1875		

8. AGE:	Years	Months	Days	If less than one day
	69	11	12	hrs. min.
Frederick County Maryland				

9. Birthplace..... (Town, county, and state)
Salesman
10. Usual occupation..... Dry Goods Business
11. Industry or business..... B.H. Blackston
12. Name..... Frederick County Maryland
13. Birthplace..... Josephine Warthan

14. Maiden name..... Frederick County Md.
15. Birthplace..... Mrs. Bertha Blackston
16. Informant..... Address 235 E. Church St. - Frederick, Md.

17. Burial..... (Burial, cremation, or removal where?) Cemetery or columbarium..... Location..... 18. Funeral director..... Address	Date thereof..... (month) (day) (year) Mount Olivet Cemetery Frederick, Md. C.E. Cline and Son Frederick, Md.
--	--

19. Date rec'd by registrar..... Address	19. 45- Elizabeth S. Heck Registrar
---	---

## 3. (b) Social Security Number

214-10-2672

## MEDICAL CERTIFICATION

2D. DATE OF DEATH.....  
August 12th. 19 45 at 8:15a.m.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Aug. 10 1945 to Aug. 12 1945  
and that I last saw him alive on Aug. 12 1945

Immediate cause of death.....  
Gastric Coronary Thrombosis  
Due to.....  
Due to.....  
Other conditions.....  
Dental extraction  
(Include pregnancy within 8 months of death)  
1/2 hrs.

Major findings of operations.....  
None

Date of op. ....

Autopsy results.....  
none -  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide.....  
Date of.....  
Where did injury occur?.....  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury.....  
Injured at work?

23. SIGNATURE.....  
A. Justin Gear M.D.  
M.D. or other  
Address.....  
Frederick, Md. Date signed.....  
8/14/45

RECEIVED

AUG 16 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

68914

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: Frederick

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?

3 1/2 yrs.

## 3. (a) FULL NAME

Sallie Shaker Brown

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

Chas. W. Brown

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan. 10, 1863

8. (c) If alive, give age years

8. AGE:

Years      Months      Days      If less than one day

82      7      5      hrs.      min.

9. Birthplace

Middletown, Frederick County, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date rec'd by registrar

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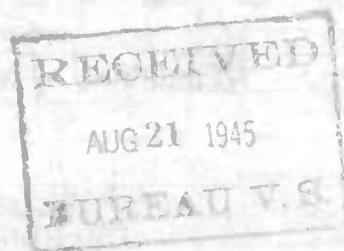
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08015

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: Frederick  
 County: Frederick  
 City or town: Frederick - Rural  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? \_\_\_\_\_  
 Hospital, Institution, or street address where death occurred: Montrose  
 How long in hospital or institution? \_\_\_\_\_

3. (a) FULL NAME Samuel Briscoe  
 4. Sex Male 5. Color or race Cloud 6. (a) Single, married, widowed, or divorced Single

7. Birth date of deceased (mo., day, yr.) Unknown 6. (c) If alive, give age ..... years

8. AGE: Years 75 Months - Days - If less than one day hrs. - min.

9. Birthplace Bucktown Md.  
 (Town, county, and state)

10. Usual occupation Farm hand

11. Industry or business John Briscoe

12. Name John Briscoe  
 MOTHER FATHER

13. Birthplace Frederick Co Md.  
 MOTHER FATHER

14. Maiden name Sarah Parker  
 MOTHER FATHER

15. Birthplace Frederick Co Md.  
 MOTHER FATHER

16. Informant Records at Montrose  
 Address Frederick Md.

17. Burial Burial Date thereof Aug 8-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Montrose

Location near Frederick Md.

18. Funeral director G. E. Gline & Son  
 Address Frederick Md.

19. Date rec'd by registrar 16-Aug-45 19.45  
 (Date rec'd by registrar) Elizabeth B. Hech Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Md. County Frederick  
 City or town near Frederick Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1945 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1945 to Aug 5 1945 and that I last saw him alive on Aug 3 1945.

Immediate cause of death

Carcinoma of Liver 3 mo.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. S. Briscoe

M. D. or other

Address Middleton Date signed 8-5-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

08016

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH: **Frederick**  
 County.....  
 City or town..... **State Sanatorium, Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **Since 7/9/45**  
 Hospital, Institution, or street address where death occurred:  
**Maryland Tuberculosis Sanatorium**  
 How long in hospital or institution? **Since 7/9/45**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... **Maryland** County..... **Carroll**  
 City or town..... **Westminster**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **154 W. Main St.**  
 (If rural, give LOCATION)

3. (a) FULL NAME  
**Edith E. Brown**

3. (b) Social Security Number  
**None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**

6. (b) Name of husband **None** **William Brown**

7. Birth date of deceased (mo., day, yr.) **August 24, 1899** 6. (c) If alive, give age ..... years

8. AGE: Years **46** Months **0** Days **2** If less than one day ..... hrs. ..... min.

9. Birthplace **Baltimore, Md.**  
 (Town, county, and state)

10. Usual occupation **Housewife**

11. Industry or business

FATHER 12. Name **Albert S. Share**

MOTHER 13. Birthplace **Baltimore, Md.**

14. Maiden name **Sue Hubbard**

15. Birthplace **Baltimore, Md.**

16. Informant **Deceased**

Address **Personal**

17. (Burial, cremation, or removal. Which?) **Burial** Date thereof **July 29, 1945** (month) (day) (year)

Cemetery or crematory **Bethesda Forest Ridge**

Location **Baltimore, Md.**

18. Funeral director **Mr. Clegg, Son**

Address **Thurmont, Md.**

19. **8/27/45** (Date filed by registrar)

Registrar

MEDICAL CERTIFICATION  
 20. DATE OF DEATH **August 26** 19 45 at 4:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **July 9** 19 45 to **August 26** 19 45 and that I last saw her alive on **August 26** 19 45

Immediate cause of death **Pulmonary Tuberculosis** DURATION **19 Mos.**

**XXX** **Tuberculous Enteritis** 1 Mo.

Due to:

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations ..... Date of op. ....

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of ....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE **John H. Hirschfelder** M. D. Atherton

Address **State Sanatorium, Md.** Date signed **8/27/45**



PLEASE WRITE PLAINLY, WITH ~~UNDERLINED~~ INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 76

## CERTIFICATE OF DEATH

08-17

Reg. Dist. No.

131

## 1. PLACE OF DEATH:

County..... Frederick

City or town..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 50 years

Hospital, institution, or street address where death occurred:

213 East Patrick St.

How long in hospital or institution?.....

## 3. (a) FULL NAME

AMON BURGEE

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Male..... White..... Married

6. (b) Name of husband or wife..... Mary Elizabeth Burgee

7. Birth date of deceased (mo., day, yr.)..... April 16, 1865

6. (c) If alive, give age..... 75 years

8. AGE: Years..... Months..... Days..... If less than one day

80..... 3..... 21..... hrs..... min.

9. Birthplace..... Hyattstown, Maryland

(Town, county, and state)

10. Usual occupation..... Retired Educator

11. Industry or business

12. Name..... Miel Burgee

13. Birthplace..... Frederick County, Maryland

14. Maiden name..... Clara Elizabeth Dawson

15. Birthplace..... Frederick County, Maryland

16. Informant..... Mrs. Amon Burgee

Address..... Frederick, Maryland

17. Burial..... Date thereof..... Aug. 9, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Olivet Cemetery

Location..... Frederick, Maryland

18. Funeral director..... C. E. Cline &amp; Son

Address..... Frederick, Maryland

19. 9-Aug-1945..... Elizabeth J. Heck

(Date rec'd by registrar) (Signature) (Title)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Frederick

City or town..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 213 East Patrick Street

(If rural, give LOCATION)

2.(a) If veteran, name war..... None

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 6..... 1945, at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1..... 1945, to..... Aug. 6..... 1945  
and that I last saw him..... alive on..... Aug. 6..... 1945

Immediate cause of death

Carcinoma of Prostate

Due to.....

Due to.....

Other conditions..... Secondary Gynaecomastia

(Include pregnancy within 3 months of death)

Major findings of operations..... None

Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... A. A. Pearce, M.D.

M. D. or other

Address..... Frederick, Md..... Date signed..... 8/9/45

RECEIVED TO TRENTON HIGH STATE CHAIFMAN  
CITY OF TRENTON NEW JERSEY



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

08918

## CERTIFICATE OF DEATH

Reg. Dist. No. 136

## 1. PLACE OF DEATH:

County. **Frederick**City or town. **Frederick-Rural R. F. D. #2**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **40 years**Hospital, institution, or street address where death occurred: **Urbana**

## How long in hospital or institution?

## 3. (a) FULL NAME

**WILLIAM CADLE**4. Sex **M** 5. Color or race **W** 6. (a) Single, married, widowed, or divorced **M**6. (b) Name of husband or wife **Vaudelia Tschiffely****61**6. (c) If alive, give age **years**7. Birth date of deceased (mo., day, yr.) **February 7, 1859**8. AGE: **86** Years **6** Months **6** Days If less than one day **hrs. min.**9. Birthplace **Anne Arundle County Maryland**

(Town, county, and state)

10. Usual occupation **Retired Farmer**

## 11. Industry or business

12. Name **James Cadle**13. Birthplace **Maryland**14. Maiden name **Susanna Woodward**15. Birthplace **Maryland**16. Informant **Dr. William R. Cadle**Address **Emmitsburg, Maryland**

## 17. Burial

(Burial, cremation, or removal. Which?) **Mount Olivet Cemetery**Date thereof **8/15/45**

(month) (day) (year)

Cemetery or crematory **Mount Olivet Cemetery**Location **Frederick, Maryland**18. Funeral director **M. R. Etchison and Son**Address **Frederick, Maryland**19. **Aug 15**

19. H. 6

*H. O. Etchison*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland**County **Frederick**City or town **Frederick-Rural R. F. D. #2**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **Urbana**

(If rural, give LOCATION)

2.(a) If veteran, name war **None**

## 3. (b) Social Security Number

**None**

## MEDICAL CERTIFICATION

20. DATE OF DEATH **August 13th, 1945**

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

**Aug 13** 1945, to **Aug 13** 1945and that I last saw him **alive** on **Aug 13** 1945Immediate cause of death **Coronary Thrombosis**DURATION **2h**Due to **Coronary Thrombosis**Due to **Coronary Thrombosis**Other conditions **Coronary Thrombosis**

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury **Coronary Thrombosis**

Injured at work?

23. SIGNATURE *H. O. Etchison*

M. D.

Address **Frederick, Maryland**

M. D. or other

8-14-45

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

68619

Reg. Dist. No. 139

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: **Frederick**  
 County.....  
 City or town..... **State Sanatorium, Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... **Since 6/18/45**  
 Hospital, Institution, or street address where death occurred:.....  
**Maryland Tuberculosis Sanatorium**  
 How long in hospital or institution?..... **Since 6/18/45**

3. (a) FULL NAME  
**Walter Coleman**

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<b>Male</b>	<b>White</b>	<b>Separated</b>

6. (b) Name of ~~wife~~ wife..... **Audrey Coleman**

7. Birth date of deceased (mo., day, yr.)..... **August 21, 1914**

8. AGE: Years	Months	Days	If less than one day
<b>30</b>	<b>11</b>	<b>17</b>	hrs. ..... min.

9. Birthplace..... **West Virginia**  
 (Town, county, and state)

10. Usual occupation..... **Painter**

11. Industry or business.....  
 FATHER 12. Name..... **Benjamin Coleman**

MOTHER 13. Birthplace..... **W. Va.**

14. Maiden name..... **Viola Cummings**

15. Birthplace..... **W. Va.**

16. Informant..... **Deceased**

Address.....

17. Burial..... **Burial** Date thereof..... **Aug. 10, 1945**  
 (Burial, cremation, or removal. Which?) **mt. Olivet** (month) (day) (year)

Cemetery or crematory..... **Card will be sent in**  
 Location..... **when received from** **Frederick Ave.**

18. Funeral director..... **Undertaker C. F. Hoffman**

Address..... **1639 N. Broadway**

19. **8/7/45** (Date rec'd by registrar) 19.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... **Maryland** County.....  
 City or town..... **Baltimore**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... **1125 Abbott Street**  
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number  
**21707-6179**

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **August 7** 1945, at **3 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **June 18** 1945, to **August 7** 1945, and that I last saw her **alive** on **August 7** 1945.

Immediate cause of death..... **Pulmonary Tuberculosis** DURATION **8 Mos.**

~~xxxxx~~ **Laryngeal Tuberculosis** **4 Mos.**

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

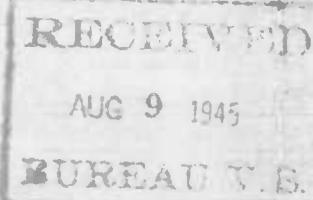
Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, Industry, public place (where?).....

Means of Injury..... Injured at work?.....

23. SIGNATURE..... **J. D. L.** M. D. **John D. L.**

Address..... **State Sanatorium, Md.** Date signed..... **8/7/45**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

08920

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County Frederick  
 City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hours  
 Hospital, institution, or street, address where death occurred:

Frederick City Hospital  
240 hours

How long in hospital or institution? .....

## 3. (a) FULL NAME

Conner, William Henry

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Mettie Hesson Conner

7. Birth date of deceased (mo., day, yr.)

Nov. 12, 1870

6. (c) If alive, give age ✓ years

8. AGE:

Years	Months	Days	If less than one day
74	9	9	hrs. min.

9. Birthplace

Maryland  
 (Town, county, and state)

10. Usual occupation

clerk in store

11. Industry or business

—

MOTHER FATHER

12. Name David Conner

13. Birthplace Maryland

14. Maiden name Anna (McKell) Conner

15. Birthplace Maryland

16. Informant Miss Cassandra Hesson

Address Thurmont, Maryland

17. Burial Burial Date thereof 8-23-45  
 (Burial, cremation, or removal which?) (month) (day) (year)

Cemetery or removal United Brothers Cemetery

Location Thurmont, Maryland

18. Funeral director Wichard & Creger

Address Thurmont, Maryland

19. Aug. 23 - 1945 Elizabeth G. Deek  
 (Date rec'd by registrar) E.M.H. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Thurmont  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ✓

(If rural, give LOCATION)

2. (a) If veteran, name war ✓

## 3. (b) Social Security Number

212-14-7027

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 21, 1945 at 10 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 20, 1945 to August 21, 1945and that I last saw him alive on August 21, 1945

Immediate cause of death

Cerebral thrombosis

DURATION

1 dayDue to artery sclerosis

?

Due to

Other conditions Diabetes 19-11145

?

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

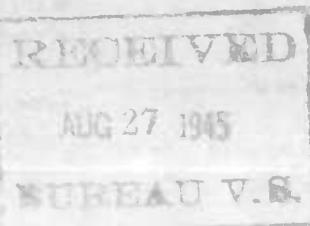
Injured at work?

23. SIGNATURE

J. R. Schowman M.D.

M. D. or other

Address Frederick Md Date signed 8/21/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4821

## CERTIFICATE OF DEATH

18821  
P41

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years Months Days If less than one day

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or removal) When

Date thereof (mo.) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Aug. 15. 1945

(Date rec'd by registrar) (Name of Registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Frederick

City or town..... Frederick (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 13 1945, at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 1 1945, to Aug 13 1945, and that I last saw her alive on Aug 12 1945.

Immediate cause of death..... Myocardial failure

DURATION 2 days

Due to..... Malnutrition

1 mo

Due to..... Coronary Atherosclerosis

(?)

Primary carcinomatous uterus.

Other conditions..... Senility Advanced

disease.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

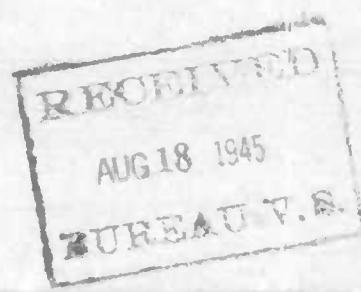
Injured at work?

23. SIGNATURE..... G. J. Brice

M. D. or other

Address..... Jefferson

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

68022

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

## 1. PLACE OF DEATH:

County

Frederick

City or town

Brunswick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

55 yrs.

Hospital, institution, or street address where death occurred:

112 7th St. 5th Ave.

How long in hospital or institution?

## 3. (a) FULL NAME

John Peter Detrich

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

## 6. (b) Name of husband or wife

Mary C. Sheffer

7. Birth date of deceased (mo., day, yr.)

May 13 - 1865

8. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual occupation

B&amp;OKR Laborer

11. Industry or business

Retired

12. Name

John P. Detrich

13. Birthplace

Germany

14. Maiden name

Elizabeth

?

15. Birthplace

Germany

16. Informant

Mr. William M. Blundin

Address

Brunswick Md

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof Sept 1, 1945

(month) (day) (year)

Cemetery or crematory

not at all

Location

Frederick Md

18. Funeral director

Co. H. Fult &amp; Son

Address

Brunswick Md

19. (Date rec'd by registrar)

Sept 1, 1945

Date rec'd by registrar

Emma Martin

Reg. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Frederick

City or town

Brunswick

County

Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

112

7th St.

5th Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 30

1945, et 4 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 28, 1945, to Aug 30, 1945

and that I last saw him alive on

Aug 28, 1945, to Aug 30, 1945

Immediate cause of death

Decompenated heart

DURATION

?

Due to

Cardiac reperfusion

?

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Charles Langford

M. D. or other

Address

Bucksweir R. Rd. Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

08023

Reg. Dist. No. 131

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Frederick

City or town

Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

S

8. (b) Name of husband or wife

B. (c) If alive, give age, years

7. Birth date of deceased (mo., day, yr.)

August 19, 1945

8. AGE:

Years  
0Months  
0Days  
10If less than one day  
hrs. .... min.

9. Birthplace

Frederick-Frederick-Maryland

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

Raymond H. Ford

12. Name

MOTHER

FATHER

Berryville, Virginia

Kathleen Sease

14. Maiden name

15. Birthplace

Martinsburg, West Virginia

Raymond H. Ford

16. Informant

Address

#10 Hillside Apts, Frederick, Md.

Burial

(Burial, cremation, or removal. Which?)

Date thereof  
(month) (day) (year)

Mount Olivet Cemetery

Cemetery or ground

Location

Frederick, Maryland

18. Funeral director

Address

M. R. Etchison and Son

Frederick, Maryland

19. Date rec'd by registrar

Date

1945

Elizabeth G. Heck  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Frederick

City or town

# outside city or town limits, write RURAL and give nearest town

Street No.

10 Hillside Apts.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 29, 1945 at 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 19, 1945, to Aug. 29, 1945  
and that I last saw her alive on Aug. 28, 1945.

Immediate cause of death

Edema of liver  
Pneumonia 8 months

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. D. Thomas M. D.

Address Frederick, Maryland Date signed 8-29-45

RECEIVED BY THE ATTORNEY GENERAL

U. S. DEPARTMENT OF JUSTICE

RECEIVED

AUG 30 1945

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

08024

## CERTIFICATE OF DEATH

Reg. Dist. No. 132

## 1. PLACE OF DEATH:

County Frederick

City or town Middletown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Baby Boy Beaver

4. Sex

5. Color or race

(a) Single, married, widowed, or divorced

Male white

8. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 25, 1945

8. AGE: Years Months Days If less than one day

0 0 0 13 45 hrs. 0 min.

9. Birthplace Middletown, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Everett W. Beaver

13. Birthplace Middletown, Md.

14. Maiden name Anabell Holden

15. Birthplace Weaverton, Md.

16. Informant Anabell Beaver

Address Middletown, Md.

17. Burial Date thereof 8-25-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Middletown, Md.

18. Funeral director Bladhill Co.

Address Middletown, Md.

19. Aug 25, 1945 Main Bladhill  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Frederick

City or town Middletown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1945 at 1:04 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 25 1945 to Aug 25 1945

and that I last saw him alive on Aug 25 1945

Immediate cause of death

Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

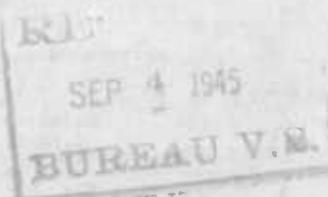
Means of injury

Injured at work?

23. SIGNATURE

J E Harp md M. D. or other

Address Middletown Date signed Aug 25 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8025  
137

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 137

## 1. PLACE OF DEATH:

County. Frederick

City or town. Mount Airy - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

Near Linganore

How long in hospital or institution?

## 3. (a) FULL NAME

KENRY WALTER HAHN

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M W M

6. (b) Name of husband or wife. Elsie Lease

7. Birth date of deceased (mo., day, yr.) July 30, 1875 8. (c) If alive, give age. 58 years

8. AGE: Years Months Days If less than one day 70 0 8 hrs. min.

9. Birthplace. Walkersville-Frederick-Maryland (Town, county, and state)

10. Usual occupation. Farmer

## 11. Industry or business

12. Name. John M. Hahn

13. Birthplace. Unknown

14. Maiden name. Margaret E. Werking

15. Birthplace. Unknown

16. Informant. Mrs. Elsie L. Hahn

Address. Mount Airy, Md. R. F. D.

## 17. Burial

(Burial, cremation, or removal. Which?) Date thereof. 8/11/45 (month) (day) (year)

Cemetery or crematory. Fairmount Cemetery

Location. Libertytown, Maryland

18. Funeral director. M. R. Etchison and Son

Address. Frederick, Maryland

19. Aug 10 1945

(Date rec'd by registrar)

M. R. Etchison

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. Maryland County. Frederick

City or town. Mount Airy - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Linganore

(If rural, give LOCATION)

2. (a) If veteran, name war. None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH. August 8, 1945, at 10:20 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 to Aug 7, 1945, to Aug 8, 1945, and that I last saw him alive on Aug 7, 1945.

Immediate cause of death.

Diabetes Mellitus Advanced

Due to.

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

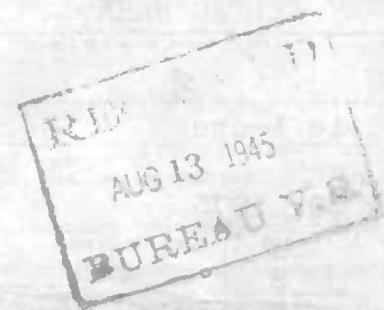
Means of injury

Injured at work?

23. SIGNATURE. C. M. Van Soale M. D.

M. D. or other

Address. Mount Airy, Maryland Date signed 8-9-45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

## CERTIFICATE OF DEATH

Rog. Diat. No. 080263

## 1. PLACE OF DEATH:

County.....

Frederick Rural

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred.....

Emergency Hospital

How long in hospital or institution?.....

3 days

## 3. (a) FULL NAME

David Lamar Haimes

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife.....

## 7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

August 21, 1945

## 8. AGE:

Years

Months

Days

If less than one day

1/2

1/2

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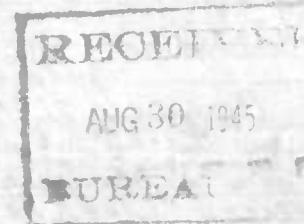
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08027

139

M. D. ~~HENRY~~

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

## 1. PLACE OF DEATH:

County..... **Frederick**  
 City or town..... **State Sanatorium, Maryland**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **Since 7/29/43**

Hospital, institution, or street address where death occurred:

**Maryland Tuberculosis Sanatorium**How long in hospital or institution?..... **Since 7/29/43**

## 3. (a) FULL NAME

**Edward Harrison Haines**4. Sex **Male** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Married**6.(b) Name of ~~Wife~~ wife..... **Mamie Haines**6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.) **March 1, 1889**8. AGE: Years **56** Months **5** Days **9** If less than one day  
..... hrs. ..... min.9. Birthplace..... **Union Bridge, Md.**  
(Town, county, and state)10. Usual occupation..... **Machinist**

11. Industry or business

12. Name..... **Frank Haines**13. Birthplace..... **Carroll County, Maryland**14. Maiden name..... **Fannie Fogle**15. Birthplace..... **Frederick County, Md.**16. Informant..... **Deceased**

Address

17. Burial..... **Burial** Date thereof **8/12/45**

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ~~Wife~~ **Mt. View**Location..... **Union Bridge, Md.**18. Funeral director..... **D. D. Hartzler & Sons**Address..... **Union Bridge, Md.**19. **8/11 1945** (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State..... **Maryland** County..... **Carroll**City or town..... **Union Bridge**

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

**None**

## MEDICAL CERTIFICATION

2D. DATE OF DEATH **August 10** 19 45 at 7:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**July 29** 19 43, to **August 10** 19 45,and that I last saw h. **1m** alive on **August 10** 19 45.

Immediate cause of death

**Pulmonary Tuberculosis**

DURATION

**2 1/2 Yrs.****Wife****Pulmonary Hemorrhage**

Few

minutes

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... M. D. ~~HENRY~~Address..... **State Sanatorium, Md.** Date signed **8/10/45**

to President



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462+

08028

131

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

Frederick

County

City or town

Frederick

(If outside city or town limits, write RURAL and give nearest town)

Lifetime

How long in above place of death?

Hospital, institution, or street address where death occurred:

106 E. 2nd. St.

How long in hospital or institution?

## 3. (a) FULL NAME

ANN ELIZABETH HALLER

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

December 18-1867

8. AGE: Years Months Days It less than one day

77 8 1 hrs. min.

9. Birthplace Frederick, Frederick Co. Md.

(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

12. Name Thomas Haller

13. Birthplace Frederick, Md.

14. Maiden name Caroline R. Fessler

15. Birthplace Frederick, Md.

16. Informant J. Fessler Haller

Address Niagara Falls, N.Y.

17. Burial Date thereof Aug. 21-1945

(Burial, cremation, or removal, where?)

(month) (day) (year)

Cemetery or cemetery Mount Olivet Cemetery

Location Frederick, Md.

18. Funeral director C.E. Cline and Son

Address Frederick, Md.

19. Date rec'd by registrar 1945

(Date rec'd by registrar)

19. 26 Aug 1945

Elizabth G. Heck

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 E. 2nd. St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 19th. 1945 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; That I attended deceased from June 26th, 1945, to August 19, 1945

and that I last saw her alive on August 18th, 1945.

Immediate cause of death

Carcinoma, Liver, and General Metastasis, extending over a period of years.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

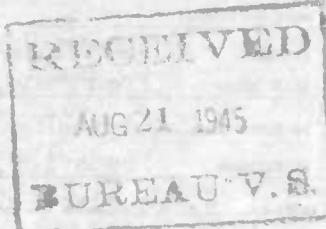
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C.H. Conley, M.D. M.D. INDEX

Address Frederick, Maryland Date signed 8/20/45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

08029

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

## 1. PLACE OF DEATH:

County.....

Frederick

City or town.....

Frederick Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?.....

7 days

## 3. (a) FULL NAME

Ara Harris

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Female

White

Widowed

## 6. (b) Name of husband or wife

Samuel Harris

## 7. Birth date of deceased (mo., day, yr.)

## 8. (c) If alive, give age..... years

Aug. 27, 1871

## 8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace.....

(Town, county, and state)

## 10. Usual occupation.....

Housewife

## 11. Industry or business.....

Hornell Shipley

FATHER

## 12. Name.....

## MOTHER

## 13. Birthplace.....

## 14. Maiden name.....

## 15. Birthplace.....

## 16. Informant.....

## Address.....

## 17. Burial.....

## (Burial, cremation, or removal where?)

## Date thereof.....

(month) (day) (year)

Aug. 31 - 45

(month) (day) (year)

Pleasant Hill

Cemetery or place.....

Location.....

Mrs. Monroe

MD

Hornell

Falconer

Funeral director.....

Address.....

New Market

MD

Elizabeth H. Harp

Harp

MD



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

08930

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County

Frederick

City or town

Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 hrs.

Hospital, Institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution? New Born

## 3. (a) FULL NAME

Dorothy Harris

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

S

B. (b) Name of husband or wife

XXXXX

7. Birth date of deceased (mo., day, yr.)

August 7th, 1945

8. (c) If alive, give age years

8. AGE:

Years  
0Months  
0Days  
0If less than one day  
2 1/2 hrs.

min.

9. Birthplace

Frederick-Frederick-Maryland  
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

12. Name

Robert Henry Harris

13. Birthplace

Topeka, Kansas

14. Maiden name

Dorothy Rozewski

15. Birthplace

Detroit, Michigan

16. Informant

Mrs. Dorothy Harris

Address

202 College Ave., Frederick, Md.

17. Burial

Date thereof 8/8/45  
(Burial, cremation, or removal. Write (month) (day) (year))

Cemetery or crematory

St. Johns Cemetery

Location

Frederick, Maryland

18. Funeral director

M. R. Etchison and Son

Address

Frederick, Maryland

19. Date rec'd by registrar

8 Aug 1945

Elizabeth G. Hedges

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Frederick

City or town

Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

212 College Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 7

19 45 at 2 30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 7, 1945, to August 7, 1945  
and that I last saw her alive on Aug 7, 1945

Immediate cause of death

Prematurity (6 mos)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. R. Schowman, D

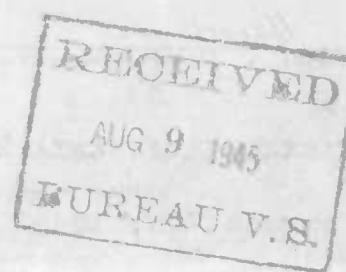
M. D. or other

Address

Frederick, Md.

Date signed

8/17/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Thad*

08031

## CERTIFICATE OF DEATH

Reg. Dlat. No. *144*

1. PLACE OF DEATH:  
County *Frederick*

City or town *Rocky Ridge-Rural R. F. D. #1*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *5 Months*

Hospital, institution, or street address where death occurred:  
*Near Creagerstown*

How long in hospital or institution? .....

3. (a) FULL NAME

**LAURA BELL HARRIS**

4. Sex <b>F</b>	5. Color or race <b>W</b>	6. (a) Single, married, widowed, or divorced <b>W</b>
-----------------	---------------------------	---

6. (b) Name of husband or wife **Martin E. Harris**

7. Birth date of deceased (mo., day, yr.) **November 2, 1870**

8. AGE: Years **74** Months **9** Days **6** Less than one day **hrs. .... min.**

8. Birthplace **Frederick County Maryland**  
(Town, county, and state)

10. Usual occupation **Practical Nurse**

11. Industry or business

12. Name **Jacob Main**

13. Birthplace **Frederick County Maryland**

14. Maiden name **Unknown**

15. Birthplace **Unknown**

16. Informant **Mrs. Harvey M. Lare**

Address **Rocky Ridge, Md. R. F. D. #1**

17. Burial Date thereof **8/10/45**  
(Burial, cremation, or removal. Which?) **(month) (day) (year)**

Cemetery or crematory **Union Chapel Cemetery**

Location **Near Liberytown, Maryland**

18. Funeral director **M. R. Etchison and Son**

Address **Frederick, Maryland**

19. Date **Aug 9** 1945- **Anna M. Jones**  
(Date recd by registrar) **Registrar**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State **Maryland** County **Frederick**

City or town **Rocky Ridge-Rural R. F. D. #1**  
(If outside city or town limits, write RURAL and give nearest town)

Street No. **Near Creagerstown**  
(If rural, give LOCATION)

2.(a) If veteran, name war **None**

3. (b) Social Security Number

**None**

## MEDICAL CERTIFICATION

2D. DATE OF DEATH **Aug 8<sup>th</sup>** 1945, at **8 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **June 5<sup>th</sup>** 1945 to **Aug 8<sup>th</sup>** 1945

and that I last saw her alive on **July 11<sup>th</sup>** 1945

Immediate cause of death **Cerebral Hemorrhage**

Due to **Chronic Endocarditis** **2 yrs**

Due to **Chronic Arterial Sclerosis** **5 yrs**

Other conditions **.....**

(Include pregnancy within 8 months of death)

Major findings of operations **.....**

Date of op. **.....**

Autopsy results **.....**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **.....** Date of **.....**

Where did injury occur? **.....** (City or town) **.....** (County) **.....** (State) **.....**

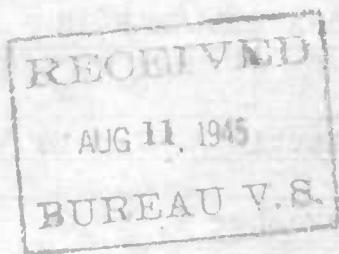
Injured at home, farm, industry, public place (where?) **.....**

Means of injury **.....** Injured at work? **.....**

23. SIGNATURE **Morris A. Bixby M.D.**

M. D. or other **.....**

Address **Thurmont - Ind** Date signed **8/8/45**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BF*

08032

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

## 1. PLACE OF DEATH:

County. **Frederick**City or town. **State Sanatorium, Maryland**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **Since 7/2/45**

Hospital, Institution, or street address where death occurred:

**Maryland Tuberculosis Sanatorium**How long in hospital or institution? **Since 7/2/45**

## 3. (a) FULL NAME

**Denver D. Hewett**

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

**Male****White****Married**8. (b) Name of ~~husband~~ wife**Agnes Hewett**

7. Birth date of deceased (mo. day, yr.)

**Sep t. 17, 1914**6. (c) If alive, give age **27** years

8. AGE:

Years

Months

Days

If less than one day

**30****10****21**

hrs.

min.

9. Birthplace

**Berkeley Springs, W. Va.**

(Town, county, and state)

10. Usual occupation

**Machine Operator**

11. Industry or business

MOTHER FATHER

12. Name

**Isaac O. Hewett**

13. Birthplace

**Fulton Co., Pa.**

MOTHER FATHER

14. Maiden name

**Rose B. Pittman**

15. Birthplace

**Fulton Co., Pa.**

16. Informant

Address

**Deceased**

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

*July 8/10/45*

(month) (day) (year)

Cemetery or crematory

*Hudson Greenway*

Location

*Berkeley Springs, W. Va.*

18. Funeral director

Address

*Krales**Stazendaire*

19. (Date rec'd by registrar)

19.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. **Maryland**

County

City or town. **Baltimore**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **1813 Linden Ave.**

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

**232-07-7760**

## MEDICAL CERTIFICATION

20. DATE OF DEATH

**August 7** 19 45 at 10:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **July 2** 1945, to **August 7** 1945, and that I last saw him alive on **August 7** 1945.

Immediate cause of death

**Pulmonary Tuberculosis**

DURATION

**4 Yrs.**

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*I. Bayon*M. D. *John Bayon*Address. **State Sanatorium, Md.** Date signed **8/8/45**



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

W-2

08033

## CERTIFICATE OF DEATH

Reg. Dist. No. 140

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

B. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

12

hrs.

min.

9. Birthplace.....

Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial, cremation, or removal. Which?

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date record by registrar.....

(Date record by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

Street No.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1945 - 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 5 - 1945 to Aug. 6 1945

and that I last saw him alive on Aug. 5 - 1945

Immediate cause of death.....

Cholera in facitum 5 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

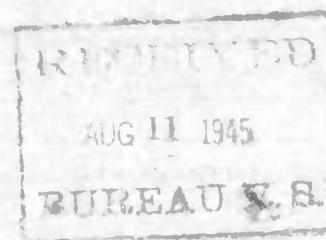
Means of injury

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed Aug. 6/45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

08034

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

## 1. PLACE OF DEATH:

County FrederickCity or town Brunswick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 da.Hospital, institution, or street address where death occurred: St. Mary's Hospital

How long in hospital or institution? \_\_\_\_\_

## 3. (a) FULL NAME

Phoebe E. Hood4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife E. M. Hood7. Birth date of deceased (mo., day, yr.) Feb. 25 1868 6. (c) If alive, give age 78 years8. AGE: Years 77 Months 5 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Horse12. Name Wm. H. Hough13. Birthplace Virginia14. Maiden name Harrison Williams15. Birthplace Virginia16. Informant Da E. M. HoodAddress Frederick, Md.17. Burial Burial Date thereof Aug 4 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WaterfordLocation Waterford, Virginia18. Funeral director L. H. Felt & SonAddress Brunswick, Md.19. Date registered by registrar Aug 2 1945 Emma Martin  
(Date record by registrar) Dep. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County FrederickCity or town Waterford, Virginia

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION) \_\_\_\_\_

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1945 at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1945 to Aug 1 1945 and that I last saw her alive on Aug 1 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

10 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

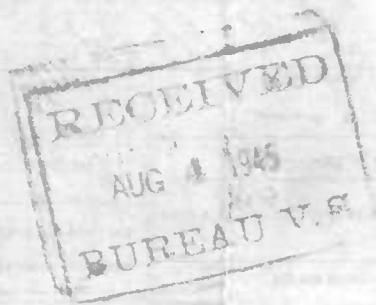
Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE W.B. Carpenter

M. D. \_\_\_\_\_

Address Montgomery, Va. Date signed 8/3/45



PLEASE WRITE PLAINLY, WITH ~~INK~~ INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore, Md.

08035

131

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yearsHospital, Institution, or street address where death occurred: 309 West College TerraceHow long in hospital or institution? none

## 3. (a) FULL NAME

Cora May Keefer4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced single6. (b) Name of husband or wife: none7. Birth date of deceased (mo. day, yr.) June 10 1858 8. (c) If alive, give age years8. AGE: Years 87 Months 1 Days 27 If less than one day hrs. min.9. Birthplace Frederick, Frederick, Md (Town, county, and state)10. Usual occupation none11. Industry or business noneFATHER 12. Name Hiram Keefer 13. Birthplace Frederick, MdMOTHER 14. Maiden name Margaret Ann Waller 15. Birthplace Frederick, Md16. informant Mrs. Lavin Michael 17. Address Frederick, Md17. Burial, cremation, or removal, When? 8/19/45 Date thereof 8/19/45

(month) (day) (year)

Cemetery or Mt. Olivet Location Frederick, Md18. Funeral director Harry E. Carty CoAddress Frederick, Md19. Date rec'd by registrar 8 Aug 1946(Date rec'd by registrar) Elizabeth G. Hecke

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 309

West College Terrace

(If rural, give LOCATION)

2. (a) If veteran, name war none

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her ~~alive~~ dead Aug 7 1945 to 10:30 A.M.

Immediate cause of death

Coronary occlusion

DURATION

Immediate

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ruthan

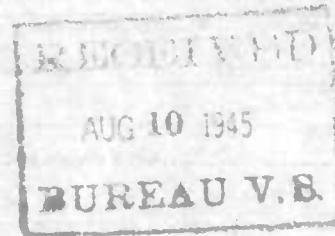
M. D. or other

Address Frederick, Md Date signed 88-53

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ALL INFORMATION CONTAINED IS UNCLASSIFIED

DATE 08-26-2016 BY 60250



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

## CERTIFICATE OF DEATH

08036

132

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County FrederickCity or town Middleton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Lora Lighter Kefauver

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white widowed

6. (b) Name of husband or wife Miriam Kefauver

7. Birth date of deceased (mo., day, yr.)

June 6, 1890

6. (c) If alive, give age ..... years

8. AGE:

Years 55 Months 2 Days 0 If less than one day hrs. ..... min.

9. Birthplace

Middleton, Frederick Co., Md.  
(Town, county, and state)

10. Usual occupation

Clerk Ration Board

11. Industry or business

12. Name Daniel Lighter13. Birthplace Middleton, Md.14. Maiden name Annie Miller15. Birthplace Middleton, Md.16. Informant Miriam KrentzAddress Frederick, Md.

17. Burial

Date thereof 8-9-45  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)Cemetery or crematory Reform CemeteryLocation Middleton, Md.

18. Funeral director

Address Gladhill Co.

19. Date rec'd by registrar

Aug 8 1945Name Maria Gladhill

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty FrederickCity or town Middleton

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

220-18-1188

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 6 1945 at 11A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 5 1945 to Aug 6 1945  
and that I last saw her alive on Aug 6 1945

Immediate cause of death

Cerebral Hemorrhage

Due to

Due to

Other conditions

(Indicate pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? Middleton (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

J. E. Hupp Jr. Date signed 8-8-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08037

## CERTIFICATE OF DEATH

141  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County

Frederick

City or town

Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, Institution, or street address where death occurred:

112 West C St

How long in hospital or institution?

## 3. (a) FULL NAME

Sallie Ann Martin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

B. (b) Name of husband or wife

Moses A. Martin

7. Birth date of deceased (mo., day, yr.)

Mar 4 1863

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

92 4 29

hrs.

min.

9. Birthplace

West Virginia

(Town, county, and state)

10. Usual occupation

11. Industry or business

Emanuel Miller

12. Name

Sarah Turner

13. Birthplace

West Virginia

14. Maiden name

Sarah Turner

15. Birthplace

West Virginia

16. Informant

Mrs. Walla C. W. Miller

Address

Brunswick Md.

17. Burial

Burial

Date thereof Aug 6 1948

(Burial, cremation, or removal, which)

(month)

(day)

(year)

Cemetery or crematory

Repose

Location

Shepherdstown W. Va.

18. Funeral director

C. H. Zell &amp; Son

Address

Brunswick Md.

19. Date recd. by registrar

Aug 6 - 1945

Emma Martin

Reg. No. 8/5/45

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Baltimore

City or town Brunswick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 West C St

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 6

19

45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1945 to Aug 6 1945

19

45

and that I last saw her alive on Aug 6 1945

19

45

Immediate cause of death

Fall - slipped on bedroom floor

DURATION

sec

Due to Accidental fall 2. Slipped on bedroom floor

caused

Due to

Fracture right pelvis

DURATION

sec

Other condition

Thromb

Aug 6 1945

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide. Accident Date of op. Aug 6 1945

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At home

Means of injury Accident fall Injured at work?

23. SIGNATURE

Signature

M. D. or other

Address

Date signed 8/5/45



PLEASE WRITE PLAINLY, WITH **UN**ADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2400

## CERTIFICATE OF DEATH

08038

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County

Old Braddock

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

96 years

Hospital, institution, or street address where death occurred:

Old Braddock

How long in hospital or institution?

## 3. (a) FULL NAME

Charles E. Klein

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife

Tenore Blanche

Stoner

6. (c) If alive, give age

69

years

7. Birth date of

deceased (mo., day, yr.)

June 6, 1866

8. AGE:

Years

Months

Days

If less than one day

79

2

1

hrs.

min.

9. Birthplace

Old Braddock, Frederick, Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Samuel Klein

12. Name

Old Braddock

13. Birthplace

Ely, Smith

14. Maiden name

Frederick, Co. Md

15. Birthplace

Mrs. Charles E. Klein

16. Informant

Old Braddock, Md

17. Burial

Date thereof Aug 9 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or cemetery

Mt Olivet

Location

Frederick, Md

18. Funeral director

Harry J. Early Co

Address

Frederick, Md

19. 8 Aug

(Date rec'd by registrar)

1945

Elizabeth G. Heck.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Frederick

City or town

Rural

Old Braddock

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Old Braddock

none

(If rural, give LOCATION)

2. (a) If veteran, name war

none

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 7 1945 at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. 17 dead 19. to 19.

and that I last saw h. 17 alive on Aug 7 1945

Immediate cause of death

Coronary occlusion

DURATION

Unconscious

15 years

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

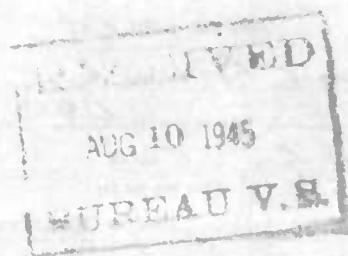
23. SIGNATURE

10-W. Bon

M. D. or other

Address

Frederick, Md Date signed 8.7.45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08939

Reg. Dist. No. 131

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: Frederick  
County: Frederick

City or town: Frederick  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:  
West 7th Street, Ext.

How long in hospital or institution? —

## 3. (a) FULL NAME

NAOMI CORNELIA KREPPS

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6. (b) Name of husband or wife: John Henry Krepps

7. Birth date of deceased (mo., day, yr.) January 16, 1878

8. AGE: Years 67 Months 6 Days 18 If less than one day — hrs. — min. —

9. Birthplace: Martinsburg, W. Va.  
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

12. Name: Rev. Luther Nickels

13. Birthplace: Braddock, Maryland

14. Maiden name: Cornelia Schroyer

15. Birthplace: Braddock, Maryland

16. Informant: John H. Krepps

Address: Frederick, Maryland

17. Burial: Burial Date thereof: Aug. 6, 1945  
(Burial, cremation, or removal, which)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Frederick, Maryland

18. Funeral director: C. E. Cline & Son

Address: Frederick, Maryland

19. Date rec'd by registrar: 6 Aug 1945 Elizabeth L. Heck  
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick  
(If outside city or town limits, write RURAL and give nearest town)

Street No.: West Seventh St., Ext.  
(If rural, give LOCATION)

2. (a) If veteran, name war: None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

August 4

19 45 at 12:15 P.M.

20. DATE OF DEATH: July 16, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16, 1945 to Aug 4, 1945 and that I last saw her alive on July 30, 1945.

Immediate cause of death: Cordial Groping

Due to: Hypertension

Duration: 15 days

Due to: Stroke

Other conditions: Stroke

DURATION: 5 years

(Include pregnancy within 3 months of death)

## Major findings or operations.

Date of op.

## Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

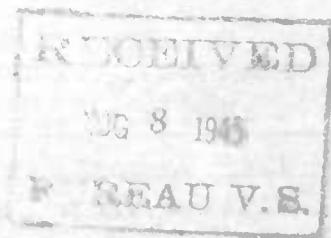
Means of injury: — Injured at work? —

23. SIGNATURE: A. H. Hegde M. D. or other —

Address: Frederick Md Date signed: Aug 4, 1945

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STATE OF ILLINOIS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and briefly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3D

08940

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:  
County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital

3 Days

How long in hospital or institution?

3. (a) FULL NAME

ANNIS ELIZABETH LANSDALE4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced MB.(b) Name of husband Dr. Philemon S. LansdaleB.(c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) June 5, 18828. AGE: Years 63 Months 2 Days 12 If less than one day hrs. .... min.9. Birthplace Bristol, Virginia

(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Robert Pyle13. Birthplace TennesseeMOTHER 14. Maiden name Mary Ledbetter15. Birthplace Virginia16. Informant Mr. Nelson LansdaleAddress Frederick, Maryland

17. Cremation

Date thereof 8/20/45

(month) (day) (year)

(month) (day) (year)

(month) (day) (year)

~~Method of cremation, as removal, which~~ Fort Lincoln CrematoryLocation Washington, D. C.18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 18 Aug 1945

(Date rec'd by registrar)

Elizabeth H. Heels2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State Maryland County FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 35 East Church Street

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 17th, 1945 at 2P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14th, 1945 to August 17, 1945 and that I last saw her alive on August 17th, 1945.

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 Days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert S. Pyle Md.

M. D. or other

Address Frederick, Maryland Date signed 8-18-45

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AUG 21 1945

LIBRARY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

## CERTIFICATE OF DEATH

08941

139

Reg. Dist. No.

1. PLACE OF DEATH: **Frederick**  
County.....

City or town **State Sanatorium, Maryland**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **Since 5/24/42**

Hospital, institution, or street address where death occurred:  
**Maryland Tuberculosis Sanatorium**

How long in hospital or institution?..... **Since 5/24/42**

## 3. (a) FULL NAME

**Patrick Maguire**

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<b>Male</b>	<b>White</b>	<b>Single</b>

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo. day. yr.) **June 21, 1899**

8. AGE: Years **46** Months **2** Days **3** If less than one day  
hrs. ..... min. ....

9. Birthplace **Ireland**  
(Town, county, and state)

10. Usual occupation **Steam Fireman**

11. Industry or business

12. Name **Patrick Maguire**

13. Birthplace **Ireland**

14. Maiden name **Mary Longman**

15. Birthplace **Ireland**

16. Informant **Deceased**

Address

17. Burial **Burial** Date thereof **Aug. 24, 1945**  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory **Blue Ridge**

Location **Thurmont, Md.**

18. Funeral director **M. L. Creager & Son**

Address **Thurmont, Maryland**

19. **8/24/45** Date rec'd by registrar **John H. Kinsella, M.D.**  
(Date rec'd by registrar) **19** Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State **Maryland** County.....

City or town **Baltimore**  
(If outside city or town limits, write RURAL and give nearest town)

Street No. **3706 Spaulding Ave.**  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

**215-16-5726**

## MEDICAL CERTIFICATION

20. DATE OF DEATH **August 24** 1945 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **May 24** 1945 to **Aug. 24** 1945, and that I last saw him alive on **August 24** 1945.

Immediate cause of death **Pulmonary Tuberculosis** DURATION **7 Yrs.**

Complicated by: **Pott's Disease** DURATION **4 Yrs.**

**Psoriasis** Abscess DURATION **1 Yr.**

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE **John H. Kinsella, M.D.** M. D. **8/24/45**

Address **State Sanatorium, Md.** Date signed **8/24/45**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3d

## CERTIFICATE OF DEATH

08042 131  
Reg. Dlat. No.

1. PLACE OF DEATH:  
County..... Frederick  
City or town..... Frederick-Rural R. F. D. #3  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 35 years  
Hospital, Institution, or street address where death occurred:..... Pleasant Hill  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Frederick  
City or town..... Frederick-Rural R. F. D. #3  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... Pleasant Hill  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... None

## 3. (a) FULL NAME

CLARA REBECCA MARTZ

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

8.(b) Name of husband or ..... George S. Martz

7. Birth date of deceased (mo., day, yr.) October 2, 1867

8. AGE: Years	Months	Days	If less than one day
77	10	13	hrs. min.

8. Birthplace..... Highland-Frederick-Maryland  
(Town, county, and state)

10. Usual occupation..... At Home

## 11. Industry or business

12. Name..... Alias Warner

13. Birthplace..... Frederick County Maryland

14. Maiden name..... Martha Ellen Green

15. Birthplace..... Frederick County Maryland

18. Informant..... Miss Ethel V. Martz

Address..... Frederick, Md. R. F. D. #3

17. Burial..... Date thereof..... 8/17/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ..... Mount Olivet Cemetery

Location..... Frederick, Maryland

18. Funeral director..... M. R. Etchison and Son

Address..... Frederick, Maryland

19. 16-Aug..... 19. 45-  
(Date rec'd by registrar) *Elizabeth J. Hecks.* Registrar

3. (b) Social Security Number  
None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 15th, 1945 at 9:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31st 1945 to August 15, 1945

and that I last saw her alive on August 15th, 1945

Immediate cause of death..... Arteriosclerosis

Chronic Myocarditis

Due to..... Cardiac Dilatation

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... *Robert L. Legge* M. D.

M. D. or other

Address..... Frederick, Maryland Date signed..... 8-16-45



1. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08643

131

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:  
County..... Frederick  
City or town..... Frederick  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death..... 30 Years  
Hospital, institution, or street address where death occurred:  
704 East Patrick Street  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Frederick  
City or town..... Frederick  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 704 East Patrick Street  
(If rural, give LOCATION)  
None  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
BESSIE VICTORIA NUSBAUM

3. (b) Social Security Number  
None

4. Sex..... F 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... S

6. (b) Name of husband or wife.....  
6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... August 6, 1883

8. AGE: Years..... 62 Months..... 0 Days..... 19 If less than one day  
hrs..... min.

B. Birthplace..... Mount Airy-Carroll-Maryland  
(Town, county, and state)

10. Usual occupation..... At Home

11. Industry or business  
FATHER 12. Name..... Henry F. Nusbaum  
13. Birthplace..... Frederick County Maryland

MOTHER 14. Maiden name..... Sarah J. Snyder  
15. Birthplace..... Carroll County Maryland

16. Informant..... Miss Ada Katharine Nusbaum  
Address..... 704 E. Patrick St., Frederick, Md.

17. Burial  
(Burial, cremation, or removal, where?)..... Cemetery or crematory..... Date thereof..... 8/28/45  
(month) (day) (year)

Location..... Mount Olivet Cemetery  
Frederick, Maryland

18. Funeral director..... M. R. Etchison and Son  
Address..... Frederick, Maryland

19. Date rec'd by registrar..... 19. 27 - Aug 19. 4.5 -  
(Date rec'd by registrar)..... Registrars..... Elizabeth L. Hock

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 25, 1945, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 2 1945 to Aug 25 1945  
and that I last saw her alive on August 25 1945

Immediate cause of death.....  
Angina.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... B. O. Thomas M. D.

M. D. or other

Address..... Frederick, Maryland Date signed 8-27-45

RECEIVED IN INTEGRATED STATE GRANT PROGRAM

117-30100-STATEMENT



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

## CERTIFICATE OF DEATH

118044 131  
Reg. Dist. No. ....

1. PLACE OF DEATH:  
County Frederick  
City or town Frederick (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 11 days  
Hospital, institution, or street address where death occurred: Frederick City Hospital  
How long in hospital or institution? 11 days

3. (a) FULL NAME  
BABY BOY PAINTER

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Aug 25

8. AGE: Years 0 Months 0 Days 0 If less than one day  
11 hrs. 35 min.

9. Birthplace Frederick, Montg Co, Md  
(Town, county, and state)

10. Usual occupation none

11. Industry or business Freelance Painter

12. Name Frederick Painter

13. Birthplace Frederick, Md

14. Maiden name Anne Elizabeth Daniels

15. Birthplace Frederick, Md

16. Informant Mrs. Lorraine D. Painter

Address Frederick, Md

17. Burial Date thereof Aug 26-45

(Burial, cremation, or removal. Which?) Monocacy

Cemetery or crematory Monocacy

Location Bethelville, Md

18. Funeral director Tom B. Miles

Address Bethelville, Md

19. 26 Aug 1945 Elizabeth Heck

(Date rec'd by Registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State  Maryland County Montgomery  
City or town Frederick (If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war ✓

3. (b) Social Security Number none

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 25-1945 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/25-1945 to 8/25-1945

and that I last saw him alive on 8/25-1945 to 8/25-1945

Immediate cause of death Premature birth (6 weeks) DURATION 1 week

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

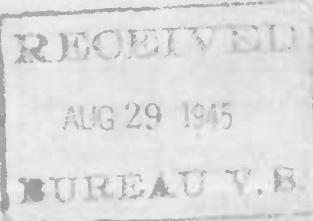
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE B. S. White, M.D. M. D. or other \_\_\_\_\_

Address Bethelville, Md Date signed 8/25/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 119

08045

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:  
County *Frederick*  
City or town *Rural*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred

*Emergency Hospital*

How long in hospital or institution?

*9 days*

3. (a) FULL NAME

4. Sex

Male white

5. Color or race

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 27, 1945

6. (c) If alive, give age

years

8. AGE: Years

Months

Days

If less than one day

9. Birthplace (Town, county, and state)

Baltimore, Baltimore County, Maryland

10. Usual occupation

Infant

11. Industry or business

Clayborne King

North Carolina

MOTHER FATHER

12. Name

Dollie Jane Schultz

13. Birthplace

Frederick County, Maryland

14. Maiden name

Emergency Hospital Records

16. Informant

Frederick, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

8/7/45  
(month) (day) (year)

Cemetery or crematory

Mount Olivet Cemetery

Location

Frederick, Maryland

18. Funeral director

M. R. Etchison and Son

Address

Frederick, Maryland

19. Date rec'd by Registrar

Elizabeth G. Heck

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Frederick*City *Frederick* Rural R. F. D. #3

(If outside city or town limits, write RURAL and give nearest town)

Street No. *Shookstown*

(If rural, give LOCATION)

2. (a) If veteran, name war

None

3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH *August 5, 1945*21. I CERTIFY that death occurred on the date above stated, that I attended deceased from *August 1, 1945* to *August 5, 1945*, and that I last saw him alive on *August 4, 1945*.

Immediate cause of death

*Enteritis*

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *J. S. Hay. M.D.*

M. D. or other

Address *Woodlawn* Date signed *8-6-45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 360

08046

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: Frederick

County

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

Frederick City HospitalHow long in hospital or institution? 3 days

## 3. (a) FULL NAME

Anna Marcus Shank

## 3. (b) Social Security Number

None

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FWWidowed

8. (b) Name of husband or -

Chas. M. Shank

7. Birth date of deceased (mo., day, yr.)

3-12-1864

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

81

4

27

hrs.

min.

9. Birthplace

Frederick Co. Md.

(Town, county, and state)

10. Usual occupation

Retired Housewife

11. Industry or business

Henry Keller

FATHER

12. Name

Frederick Co. Md.

13. Birthplace

Sarah Biser

14. Maiden name

Frederick Co. Md.

15. Birthplace

Frederick Co. Md.

16. Informant

Miss Catherine Alexander

Address

Middletown - Md.

17. Burial, cremation, or removal (where?)

Reformed CemeteryDate thereof 8-11-45

(month)

(day)

(year)

Cemetery or crematory

Reformed Cemetery

Location

Middletown - Md.

18. Funeral director

C. E. Cline & Son

Address

Frederick - Md.

19. Date rec'd by registrar

Aug 11 1945

(Date rec'd by registrar)

Elizabeth G. Hech

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Middletown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 8- 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 3 1945 to Aug 8 1945and that I last saw h. 2 alive on Aug 8 1945

Immediate cause of death

Pulmonary Cn. tuberc.Due to Post-tubercular venous thrombosis

Due to

Ovarian Cyst & twisted Pedicle

Other conditions

Cirrhosis - sclerosus

(Include pregnancy within 3 months of death)

Major findings or operations

Ovarian Cyst & twisted pedicleDate of op. Aug 6- 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide...

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank D. Worthen

M. D. or other

Address

Frederick - Md.Date signed Aug 11 1945

RECEIVED

AUG 13 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore



Reg. Dist. No. 139

08047-139  
Reg. Dist. No. ....

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County..... Frederick

City or town..... Sabillasville

(If outside city or town limits, write RURAL and give nearest town)

25 yrs

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Edward Columbus Shriner

## 3. (b) Social Security Number

No

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife

Ellen Mc Clain

7. Birth date of deceased (mo., day, yr.)

Jan. 16th. 1858

6. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

87 7 12 hrs. min.

9. Birthplace

MD

(Town, county, and state)

10. Usual occupation

Retired.

11. Industry or business

Manuel Shriner

12. Name

Md

13. Birthplace

Adaline Wetzel

14. Maiden name

Md

15. Birthplace

16. Informant

Morris Clark

Address

Sabillasville. Md

17. Burial

Date thereof

Aug. 30. 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Otterbreind Chapel

Location

Nr Sabillasville. Md

18. Funeral director

M. L. Creager &amp; Son

Address

Thurmont. MD.

19. Aug. 30 1945

(Date rec'd by registrar)

Blanche S. Egler

Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

MD

State.....

County.....

Frederick

City or town.....

Sabillasville

Street No.....

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war.....

No

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 27th 1945

19. 3 P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 1945 to 8-28 1945 and that I last saw him alive on 8-26 1945

Immediate cause of death

Ovarian Hypertrophy

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. G. Bridger M. D. or other

Address

H. G. Bridger Senior Aug. 30 1945



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08948

## CERTIFICATE OF DEATH

Reg. Distr. No. 131

## 1. PLACE OF DEATH:

County..... Frederick

City or town..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 65 years

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?..... 1 day

## 3. (a) FULL NAME

ALICE VIRGINIA SMITH

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6. (b) Name of husband..... John P. Smith

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... November 15-1860

8. AGE: Years	Months	Days	If less than one day
84	9	16	hrs. min.

8. Birthplace..... Washington County Maryland

(Town, county, and state)

10. Usual occupation..... Housekeeper

11. Industry or business.....

12. Name.....	Samuel Stottlemyer
13. Birthplace	Washington County Maryland

14. Maiden name.....	Don't Know
15. Birthplace	Don't Know

16. Informant..... Mrs. Gertrude Rickards

Address..... 130 E. 4th. St.-Frederick, Md.

17. Burial..... Date thereof..... Sept. 3-1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Johns Cemetery

Location..... Frederick, Md.

18. Funeral director..... C.E. Cline and Son

Address..... Frederick, Md.

19. I, the registrant..... Date rec'd by registrar..... 1945

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Frederick

City or town..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 130 East 4th. Street

(If rural, give LOCATION)

2. (a) If veteran, name war..... None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug. 31-1945 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 28-1945 to Aug. 31-1945 end that I last saw her alive on Aug. 29-1945.

Immediate cause of death.....

Carcinoma of Stomach

DURATION..... 7

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

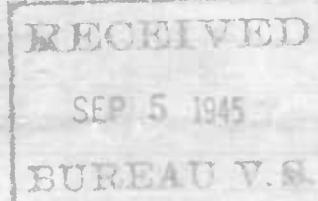
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... E. Harp M.D.

M. D. or other

Address..... Frederick, Md. Date signed..... 9-1-45



PLEASE WRITE PLAINLY, WITH UNEADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08049

131

Reg. Dist. No. 131

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Charles Wesley

4. Sex

Male white Widower

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Ida May Bitler

7. Birth date of deceased (mo., day, yr.)

September 14, 1872

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day  
72 10 24 hrs. min.

9. Birthplace: Nr. Johnsboro-Frederick-Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

12. Name Daniel D. Smith

13. Birthplace Frederick County Maryland

14. Maiden name Mary Kinny

15. Birthplace Frederick County Maryland

16. Informant Mrs. Mary A. Long

Address 212 E. 5th St., Frederick, Md.

17. Burial Date thereof 8/10/45

(Burial, cremation, or removal. Which?)

Glade Cemetery

Cemetery or (where) Walkersville, Maryland

Location

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. Date rec'd by registrar 1945

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

212 E. 5th

(If rural, give LOCATION)

2.(a) If veteran name war

None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 8

1945 at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jane 1945 to Aug 8 1945

and that I last saw h. m. alive on Aug 7 1945

Immediate cause of death

Cardio-Renal-Vascular disease

DURATION

2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

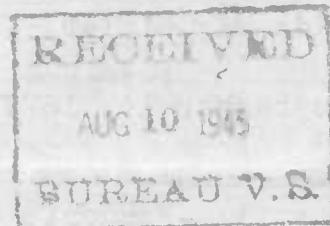
Means of injury

Injured at work

23. SIGNATURE

M. D. or other

Address Date signed 8-8-45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BD*

## CERTIFICATE OF DEATH

080541  
131

Reg. Dist. No. 131

1. PLACE OF DEATH:  
County Frederick  
City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Frederick City Hospital  
How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Frederick  
City or town Jefferson

(If outside city or town limits, write RURAL and give nearest town)

Street No.  (If rural, give LOCATION)  
2.(a) If veteran, name war None

## 3. (a) FULL NAME

NELLIE VIRGINIA SMITH

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6.(b) Name of husband George W. Smith

7. Birth date of deceased (mo., day, yr.) July 11, 1888 6.(c) If alive, give age 58 years

8. AGE: Years 57 Months 1 Days 1 If less than one day hrs. .... min.

9. Birthplace Nr. Jefferson-Frederick-Maryland  
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business John W. Pearl

12. Name John W. Pearl  
13. Birthplace Frederick County Maryland

14. Maiden name Lillie Waskey

15. Birthplace Frederick County Maryland

16. Informant Mr. George W. Smith  
Address Jefferson, Maryland

17. Burial Date thereof 8/14/45  
(Burial, cremation, or removal. Which?) St. Pauls Lutheran Cemetery  
Cemetery or cemetery Jefferson, Maryland

18. Funeral director M. R. Etchison and Son  
Address Frederick, Maryland

19. 13-Aug 1945 Elizabeth G. Heck  
(Date rec'd by registrar) Registrar

3. (b) Social Security Number None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1945 at 7:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8 1945, to Aug 12 1945, and that I last saw her alive on Aug 12 1945.

Immediate cause of death Myocardial decompression DURATION 3 days

Due to Acute Spel Bladder DURATION 5 days  
& Chronic My. cardioti 10 yrs

Due to Obesity extreme

Other conditions —  
(Include pregnancy within 8 months of death)

Major findings of operations — Date of op. —

Autopsy results —  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

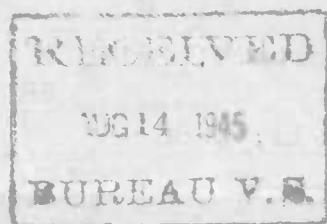
Where did injury occur? — (City or town) — (County) — (State) —

Injured at home, farm, Industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Dr. L. L. Brum M.D. M. D. or other —

Address Jefferson Date signed 8/13/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8301

08951

## CERTIFICATE OF DEATH

131

Reg. Dist. No. ....

1. PLACE OF DEATH:  
County **Frederick**  
City or town **Jefferson - Rural**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **7 Years**  
Hospital, institution, or street address where death occurred:  
**Near Jefferson**  
How long in hospital or institution? ....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State **Maryland** County **Frederick**  
City or town **Jefferson - Rural**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **Near Jefferson**  
(If rural, give LOCATION)  
2.(a) If veteran, name war **None**

3. (a) FULL NAME  
**ALBERTA CATHERINE SOUDER**

4. Sex **F** 5. Color or race **W** 6.(a) Single, married, widowed, or divorced **W**

6.(b) Name of husband or wife **George M. Souder**

7. Birth date of deceased (mo., day, yr.) **July 29, 1871** 8. (c) If alive, give age **years**

8. AGE: Years **74** Months **0** Days **21** If less than one day **hrs. min.**

9. Birthplace **Lovettsville-Loudoun-Virginia**  
(Town, county, and state)

10. Usual occupation **At Home**

11. Industry or business  
MOTHER FATHER **Jonas Slater**

12. Name **Loudoun County Virginia**

13. Birthplace **Ellen Stoneburner**

14. Maiden name **Loudoun County Virginia**

15. Birthplace **Mr. Raymond R. Souder**

16. Informant **Jefferson, Maryland**

17. Burial **8/23/45**  
(Burial, cremation, or removal. Which?) Date thereof **(month) (day) (year)**

Cemetery or crematory **Union Cemetery**

Location **Lovettsville, Virginia**

18. Funeral director **M. R. Etchison and Son**

Address **Frederick, Maryland**

19. **August 22 1945**  
(Date rec'd by registrar)

**Elijah Heck.**  
Registrar  
820

3. (b) Social Security Number **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH **August 20th, 1945** at **11:30A**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **July 26 1945** to **Aug 20 1945** and that I last saw him alive on **Aug 18 1945**

Immediate cause of death **Stroke Hemorrhage**

Due to **Hypertension**

Due to **.....**

Other conditions **.....**

(Include pregnancy within 8 months of death)

Major findings of operations **.....**

Date of op. **.....**

Autopsy results **.....**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **.....** Date of **.....**

Where did injury occur? **.....** (City or town) **.....** (County) **.....** (State) **.....**

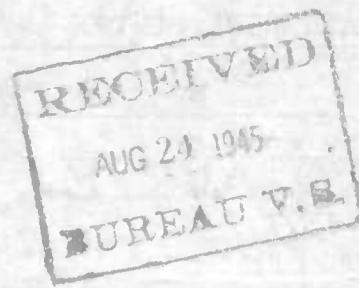
Injured at home, farm, industry, public place (where?) **.....**

Means of injury **.....** Injured at work? **.....**

23. SIGNATURE **Elizabeth Heck** M. D.

M. D. or other **.....**

Address **Brunswick, Maryland** Date signed **8-21-45**



M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. ~~Print~~ correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1600

08052

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County

City or town

Frederick, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred

Margarey Arpataly

5 days

How long in hospital or institution?

## 3. (a) FULL NAME

Frances Speake

4. Sex

Male

white

5. Color or race

Single

6. (a) Single, married, widowed, or divorced

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years      Months      Days      If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

John William Speake

Woodsboro, Maryland

12. Name

Mary Margaret Kurrey

13. Birthplace

Baptist Rockville, Md., Maryland

14. Maiden name

Virginia Hale

15. Birthplace

Margarey Arpataly

16. Informant

Frederick, Md.

17. Cemetery or crematory

Lutheran Cemetery

Cemetery or crematory

Creagerstown - Md.

18. Funeral director

C. E. Cline and Son

19. Address

Frederick - Md.

20. Date of birth

Aug. 7, 1945

(Date rec'd by registrar)

Eligible for Tech.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

City or town

Frederick (If outside city or town limits, write RURAL and give nearest town)

Street No.

65 South Market (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 4, 1945, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

July 30, 1945, to Aug. 4, 1945, and that I last saw him alive on Aug. 4, 1945.

Immediate cause of death

Premature & mouth  
(Premature separation of  
placenta)

Due to

Other conditions

Exhaustion

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. Lawrence Faherty, M.D.

M. D. or other

Address

Frederick, Md. Date signed

RECEIVED

AUG 8 1945

BUREAU V. S.

Ken Tschirhart

M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8-2

08053

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:  
County... Frederick

City... Frederick-Rural R. F. D. #1  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 8 Years

Hospital, institution, or street address where death occurred:

I. O. O. F. Home

How long in hospital or institution?... 8 Years

## 3. (a) FULL NAME

JAMES HENRY STOKES

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	S

6. (b) Name of husband or wife...

7. Birth date of deceased (mo., day, yr.) April 15, 1862  
6. (c) If alive, give age... years

8. AGE: Years	Months	Days	If less than one day
83	4	2	hrs. min.

9. Birthplace... Frederick County Maryland

(Town, county, and state)

10. Usual occupation... Cigar Maker

11. Industry or business

12. Name... Joshua Stokes

13. Birthplace... Frederick County Maryland

14. Maiden name... Anna Catherine Weller

15. Birthplace... Frederick County Maryland

16. Informant... I. O. O. F. Home Records

Address... Frederick, Md. R. F. D. #1

17. Burial... Date thereof... 8/20/45

(Burial, cremation, or removal. Where?) (month) (day) (year)

Cemetery or... United Brethren Cemetery

Location... Thurmont, Maryland

18. Funeral director... M. R. Etchison and Son

Address... Frederick, Maryland

19. 18 Aug 1945 (Date rec'd by registrar)

Elizabeth G. Heck, Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Frederick

City or town... Thurmont

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2. (a) If veteran, name war... None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH... August 17, 1945 at 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 5 1945 to Aug 17 1945  
and that I last saw him alive on Aug 17 1945

Immediate cause of death...

Cerebral Hemorrhage

Due to...

Arterialclerosis

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... None

Date of op. ....

Autopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE...

J. Julian Pearre M. D.

M. D. or other

Address... Frederick, Maryland Date signed 8-18-45

VS A15

STATED TO TRINIDAD STATE CHAMBER

BY THE STATE CHAMBER

RECEIVED

AUG 21 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore



## CERTIFICATE OF DEATH

08054/31  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Frederick  
City or town..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Lifetime

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?..... 7 days

## 3. (a) FULL NAME

FANNIE E. SUMMERS

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Female..... White..... Widowed

6. (b) Name of husband or wife..... Jonas V. Summers

7. Birth date of deceased (mo., day, yr.)..... January 25-1865

8. AGE: Years..... 80 Months..... 6 Days..... 15 If less than one day  
..... hrs. ..... min.9. Birthplace..... Middletown Valley- Maryland  
(Town, county, and state)

10. Usual occupation..... Retired Housewife

## 11. Industry or business

12. Name..... James H. Joy

13. Birthplace..... Frederick County Maryland

14. Maiden name..... Rosa Measell

15. Birthplace..... Frederick County Maryland

16. Informant..... Mrs. Charles H. Kehne

Address..... near Mt. Airy- Md.

17. Burial..... Date thereof..... August 13-45  
(Burial, cremation, or removal, which)..... (month) (day) (year)

Cemetery or crematory..... Mount Olivet Cemetery

Location..... Frederick, Maryland

18. Funeral director..... C.E. Cline and Son

Address..... Frederick, Maryland

19. M. Aug 1945..... Elizabeth G. Heck  
(Date rec'd by registrar)..... Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Frederick

City or town..... near Mt. Airy  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war..... None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... August 9th. 1945 at 10:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 4 1945 to Aug 9 1945

and that I last saw her alive on Aug 9 1945

Immediate cause of death.....

Myocarditis

Due to..... Attenoseleptase

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

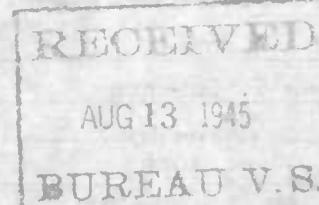
Injured at work?

23. SIGNATURE.....

M. D. or other.....  
Address..... Frederick, Md. Date signed.....

RECEIVED BY THE TWENTIETH STATE GUARDIAN

HEAD-OF-STATE GUARD



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

08055

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County ..... Frederick

City or town ..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... 3 hours

Hospital, institution, or street address where death occurred:

320 Chapel Alley

How long in hospital or institution? ..... - - -

## 3. (a) FULL NAME

BERNARD THOMAS TOBERY

## 4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

Male      White      Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)      8. (c) If alive, give age ..... years

8. AGE:      Years      Months      Days      If less than one day

- - - - -      9      - - - - - hrs.      - - - - - min.

9. Birthplace ..... Frederick, Frederick Co., Md. (Town, county, and state)

10. Usual occupation ..... Infant

## 11. Industry or business

12. Name ..... Arthur G. Tobery

13. Birthplace ..... Frederick County, Maryland

14. Maiden name ..... Florence Wetzel

15. Birthplace ..... Frederick, Maryland

16. Informant ..... Arthur G. Tobery

Address ..... Ceresville, Maryland

17. Burial ..... Date thereof ..... August 20, 1945  
(Burial, exhumation, or removal. Which?)      (month) (day) (year)

Cemetery or ground ..... Mt. Olivet Cemetery

Location ..... Frederick, Maryland

18. Funeral director ..... C. E. Cline &amp; Son

Address ..... Frederick, Maryland

19. (a) Date rec'd by registrar ..... 19. Aug. 20 - Elizabeth G. Heile. (b) Date signed ..... 19. Aug. 20 -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Maryland      County ..... Frederick

City or town ..... Ceresville - - - - - (If outside city or town limits, write RURAL and give nearest town)

Street No. - - - - - (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... August 18, 1945, at 1:50 p.m.

21. IDENTIFY that death occurred on the date above stated: that I attended deceased from

Aug. 9, 1945, to Aug. 18, 1945

and that I last saw him - - - - - alive on

Immediate cause of death

A placenta - - - - - immediately

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

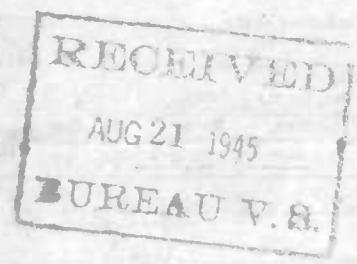
Injured at work?

23. SIGNATURE

Address

M.D. or other

Date signed



changes of items 1, 2a, 6c, 17, 21 and 22: new cer. signed by Dr. Baer, with letter from wife, filmed G89  
10-15-45. L

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 167

08056

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital

Immediate

How long in hospital or institution?

## 3. (a) FULL NAME

Mr Clyde Trumpower

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white

6. (b) Name of husband or wife Mrs Madeline Trumpower7. Birth date of deceased (mo., day, yr.) August - 30 - 19056. (c) If alive, give age 76 years8. AGE: Years 39 Months 11 Days 22 If less than one dayhrs. 00 min. 009. Birthplace Clearspring - Wash Co. - Md.

(Town, county, and state)

10. Usual occupation Blacksmith11. Industry or business W. M. R. R.12. Name Jeremiah Trumpower13. Birthplace Clearspring14. Maiden name Estelle Kinsell15. Birthplace Clearspring - Md.16. Informant Mrs. Madeline TrumpowerAddress Hagerstown - Md.17. Burial Burial Date thereof Aug - 24 - 1945(Burial, cremation, or removal. Which?) Thurmont Date of 8-21-45Cemetery or crematory Rose Hill CemeteryLocation Hagerstown - Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown - Md.19. Date rec'd by registrar Aug 22 1945(Date rec'd by registrar) Elizabeth G. Seckel

E.M. H. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State  MarylandCounty WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 710 Chestnut Street

(If rural, give LOCATION)

2. (a) If veteran, name war None Yes; War II ✓

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1945 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

dead 19 to 19and that I last saw h. 11 alive on Aug 22 1945Immediate cause of death Fraction of skullFracture of skullFracture of brainDuration ImmediateDue to fall from B/T O/R McarDue to fall from B/T O/R McarOther conditions 

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results 

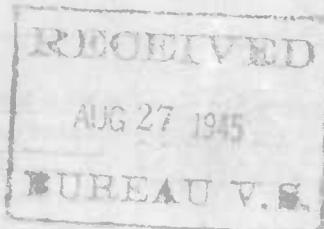
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8-21-45Where did injury occur Thurmont (City or town) MD (County) MD (State) MDInjured at home, farm, industry, public place (where?) B/T O/R M 11:45 A.M.Means of injury Fall from car Injured at work? yes23. SIGNATURE R. W. Baer M. D. or other PhysicianAddress Frederick, Md. Date signed Aug 22, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12-6

08057

## CERTIFICATE OF DEATH

Reg. Dlat. No. 131

## 1. PLACE OF DEATH:

County ..... Frederick

City or town ..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution? 2 days

## 3. (a) FULL NAME

ANNA LOUISE VAN SWEARINGEN

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or - Charles Van Swearingen

7. Birth date of deceased (mo., day, yr.) June 30-1905

6. (c) If alive, give age 46 years

8. AGE: Years Months Days If less than one day

40 1 20 . . . . . hrs. . . . . min.

9. Birthplace Woodsboro Frederick Co. Md.

(Town, county, and state)

10. Usual occupation Billing Clerk

11. Industry or business G.L. Baking Co.

12. Name Charles J.F. Miller

13. Birthplace Frederick Co. Md.

14. Maiden name Minnie A. Delaplane

15. Birthplace Frederick Co. Md.

16. Informant Charles Van Swearingen

Address 9 E. 2nd. St.-Frederick, Md.

17. Burial Date thereof August 22-45

(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Mount Olivet Cemetery

Location Frederick, Md.

18. Funeral director C.E. Cline and Son

Address Frederick, Md.

19. 20 Aug 1945

(Date rec'd by registrar)

Elizabeth J. Heck

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 E. 2nd. St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (b) Social Security Number

214-10-2624

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 19th. 1945 at 11:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 17 1945 to Aug 19 1945

and that I last saw her alive on Aug 19 1945

Immediate cause of death

Myocarditis

Due to

Due to

Other conditions Partial Bacterial obstruction

DURATION

3 days

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

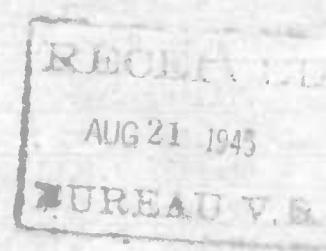
Injured at work?

23. SIGNATURE

M. D. or other

Address Frederick, Md. Date signed Aug 20 1945

40-1450-40 TRANSMISSION STATE, ONE-YEAR  
THE FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

08058

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:  
County **Frederick**  
City or town **Frederick-Rural R. F. D. #3**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **20 years**  
Hospital, institution, or street address where death occurred:  
**Near Rocky Spring**  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State **Maryland** County **Frederick**  
City or town **Frederick-Rural R. F. D. #3**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **Near Rocky Spring**  
(If rural, give LOCATION)  
2.(a) If veteran, name war **None**

3. (a) FULL NAME  
**ROSIE MAY WACHTER**

3. (b) Social Security Number  
**None**

4. Sex <b>F</b>	5. Color or race <b>W</b>	6.(a) Single, married, widowed, or divorced <b>M</b>
-----------------	---------------------------	--

6.(b) Name of husband or wife **Cornelius A. Wachter**  
6.(c) If alive, give age **71** years

7. Birth date of deceased (mo., day, yr.) **May 10, 1875**

8. AGE: Years **70** Months **3** Days **2** It less than one day  
..... hrs. ..... min.

9. Birthplace **Frederick County Maryland**  
(Town, county, and state)

10. Usual occupation **At Home**

11. Industry or business  
FATHER **Joseph Engle**  
12. Name **Frederick County Maryland**

MOTHER **Margaret Hinea**  
13. Birthplace **Frederick County Maryland**

14. Maiden name **Mr. Cornelius Wachter**  
15. Birthplace **R. F. D. #3, Frederick, Maryland**

16. Informant **R. F. D. #3, Frederick, Maryland**

17. Burial Date thereof **8/15/45**  
(Burial, cremation, or removal. Where?)  
Cemetery or cemetery **Brookhill Cemetery**

Location **Yellow Spring, Maryland**

18. Funeral director **M. R. Etchison and Son**  
Address **Frederick, Maryland**

19. Date rec'd by registrar **14 Aug 1945**

*Elizabeth G. Hecks*  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **August 12th, 1945** at **8 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **August 10th 1945** to **Aug 12th 1945** and that I last saw her alive on **Aug 12 1945**  
Immediate cause of death **Cerebral Haemorrhage** DURATION **1 week**

Due to **Cerebral Haemorrhage**

Due to **None**

Other conditions **None**

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE *H. F. Engle* M. D.  
M. D. or other

Address **Frederick, Maryland** Date signed **8-14-45**

RECEIVED

AUG 16 1945

BUREAU V. S.

✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

08059  
144

## 1. PLACE OF DEATH:

County HagerstownCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:

Now long in hospital or institution? ....

## 3. (a) FULL NAME

Gertude Delphine Waetzel

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

Thomas Waetzel

7. Birth date of deceased (mo., day, yr.)

June 21, 1876

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

69

2

0

.hrs. min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

George Pyle

13. Birthplace

Philadelphia, Pa.

MOTHER

14. Maiden name

Eliza Dorney

15. Birthplace

Mother's Station, Md.

16. Informant

Miss Jean Fox

Address

Philmont, Md.

17. (Burial, cremation, or removal. Which?)

Date thereof

Aug. 23, 1945

(month) (day) (year)

Cemetery or crematory

Mt. Tabor

Location

Georgetown, Md.

18. Funeral director

Mr. G. Cresson et al.

Address

Hagerstown, Md.

19. Aug. 23, 1945

(Date rec'd by registrar)

Blanche S. Eyer

Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HagerstownCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2. (a) If veteran, name war

no

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 23, 1945 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 21 to Aug. 21 1945and that I last saw her alive on July 15 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James GrayM.D.Address Hagerstown, Md.Date signed Aug. 23, 1945

WISCONSIN STATE GUARD

LETTER TO STANLEY



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160

08060

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

## 1. PLACE OF DEATH:

County.....

Frederick

City or town.....

Brunswick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

7 days

Hospital, institution, or street address where death occurred:

Schaeffer Hospital

How long in hospital or institution?.....

7 days

## 3. (a) FULL NAME

Wayne Eugene

Webber

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

May 18 1945

8. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

2 29

hrs.

min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

Paul S. Webber

12. Name.....

MOTHER FATHER

Maryland

13. Birthplace

Virginia

14. Maiden name

Phillips

15. Birthplace

Maryland

16. Informant

Mrs. P. S. Webber

Address

Waverly, Md.

17. Burial

Date thereof Aug 19 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Church of Brethren Cemetery

Location

Brownsville, Md.

18. Funeral director

C. W. Estate &amp; Sons

Address

Brunswick, Md.

19. Aug 19- 1945

Emma Martin-  
Sep. Registrar

(Date recd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County

Washington

City or town.....

Waverly

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Aug 17

1945, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 11 1945, to Aug 17 1945

and that I last saw him alive on Aug 17 1945

Immediate cause of death

Exhaustion

Due to

Araly disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

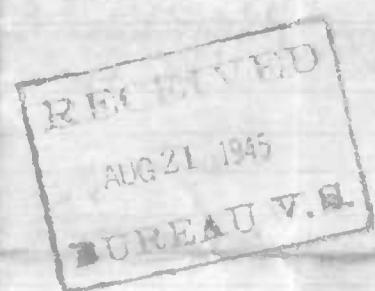
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

08061

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:  
County... **Frederick**

City or town... **Frederick**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

**Frederick City Hospital**How long in hospital or institution? **3 Days**

## 3. (a) FULL NAME

**DOCTOR ILE WEEDON**

4. Sex <b>M</b>	5. Color or race <b>C</b>	6. (a) Single, married, widowed, or divorced <b>M</b>
--------------------	------------------------------	--

B. (b) Name of husband or wife **Cecelia F. Scott**7. Birth date of deceased (mo., day, yr.) **September 15, 1892**8. (c) If alive, give age **47** years

8. AGE: Years <b>52</b>	Months <b>10</b>	Days <b>27</b>	If less than one day ..... hrs. .... min.
----------------------------	---------------------	-------------------	--

9. Birthplace **Nr. Jefferson-Frederick-Maryland**  
(Town, county, and state)10. Usual occupation **Orderly**11. Industry or business **Frederick City Hospital**12. Name **Henry A. Weedon**13. Birthplace **Frederick County Maryland**14. Maiden name **Alverta Layer**15. Birthplace **Frederick County Maryland**16. Informant **Mrs. Cecelia S. Weedon**Address **R. F. D. #4, Frederick, Md.**17. Burial Date thereof **8/15/45**(Burial, cremation, or removal. Which?) **(month) (day) (year)**Cemetery or place **Sunnyside Methodist Cemetery**Location **Near Jefferson, Maryland**18. Funeral director **M. R. Etchison and Son**Address **Frederick, Maryland**19. *14 Aug* 1945  
(Date rec'd by registrar)*Elizabeth J. Heck*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State **Maryland** County **Frederick**City or town **Frederick-Rural R. F. D. #4**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **Sunnyside**

(If rural, give LOCATION)

2.(a) If veteran, name war **None**

## 3. (b) Social Security Number

*None*

## MEDICAL CERTIFICATION

20. DATE OF DEATH **August 12th, 1945** at **10A**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

13. .... to 19. ....

end that I last saw him/her **dead** **August 12th, 1945**

## Immediate cause of death

*Compressed fracture**2 thoracic vertebrae*Due to *Causing complete**paralysis from that*Due to *point to lower extremities*

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

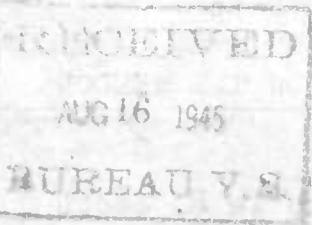
Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **Accident** Date of **8-8-45**Where did injury occur? **Nr. Jefferson-Frederick-Md.** (City or town) (County) (State)Injured at home, farm, industry, public place (where?) **Farm**Means of injury **Fell from Straw Stack** **YES** **NO** **NOT WORK**23. SIGNATURE *R. F. D. #4*  
Reputed medical examinee M.D. or otherAddress **Frederick, Maryland** Date signed **8-13-45**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

08062

## CERTIFICATE OF DEATH

Reg. Dist. No. *144*1. PLACE OF DEATH: *Frederick*

County

City or town *Rural Rocky Ridge*

(If outside city or town limits, write RURAL and give nearest town)

*3 da.*

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Bonnie Lee Welty*

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *August 9. 1945*

6. (c) If alive, give age

years

8. AGE: Years *3* Months *0* Days *0* If less than one dayhrs. *0* min. *0*9. Birthplace *Rocky Ridge, Frederick Co. MD*

(Town, county, and state)

10. Usual occupation

## 11. Industry or business

12. Name *Edgar M. Welty*

Rocky Ridge MD

13. Birthplace *Rocky Ridge MD*14. Maiden name *Laura F. Baker*15. Birthplace *Frederick MD*16. Informant *Edgar M. Welty*Address *Rocky Ridge MD*17. Burial (Burial, cremation, or removal. Which?) *Mt. Tabor Cemetery*Date thereof *Aug. 13th. 1945*

(month) (day) (year)

Cemetery or crematory

Location *Rocky Ridge MD*18. Funeral director *M. L. Creager & Son*Address *Thurmont. MD.*19. *Aug. 13 1945*  
(Date rec'd. by registrar)*Blanche S. Eyer*  
Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD* County *Frederick*City or town *Rocky Ridge* Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. *NO* (If rural, give LOCATION)2. (a) If veteran, name war *NO*3. (b) Social Security Number *NO*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug. 12 1945*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Aug. 9 1945* to *Aug. 12 1945*and that I last saw *dead* alive on *Aug. 12 1945*

Immediate cause of death

*acute Gastroenteritis*

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide *Accident* Date of *1945*

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *J. N. Legg*

M. D. or other

Address *1111 Boston* Date signed *Aug. 13 1945*

RECEIVED TO COMMERCIAL STATE BANK

REGISTRATION

REGISTRATION NUMBER

REGISTRATION



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 302

08063

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

131

## 1. PLACE OF DEATH:

County ..... FrederickCity or town ..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... 23 days

Hospital, institution, or street address where death occurred:

Frederick County JailHow long in hospital or institution? ..... 23 days

## 3. (a) FULL NAME

Virginia W. Whitman

## 4. SEX

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Female White divorced6. (b) Name of husband or wife ..... Ronald W. Whitman7. Birth date of deceased (mo., day, yr.) ..... Sept 23 - 19128. (c) If alive, give age ..... 35 years8. AGE: Years ..... 32 Months ..... 11 Days ..... 1 If less than one day ..... hrs. ..... min.8. Birthplace ..... Maryland

(Town, county, and state)

10. Usual occupation ..... None11. Industry or business ..... None12. Name ..... Alma Tucker13. Birthplace ..... Maryland14. Maiden name ..... Martia E. Grys15. Birthplace ..... Maryland16. Informant ..... Russell W. FinkleAddress ..... Hagerstown Md17. Burial, cremation, or removal. Which? ..... BurialDate thereof ..... Aug. 26, 1945  
(month) (day) (year)Cemetery or crematory ..... Mount Hope Cem.Location ..... near Hagerstown - Washington Co.18. Funeral director ..... R. H. Finkle & SonAddress ..... Baltimore Md.19. Date rec'd by registrar ..... 24 Aug 1945(Date rec'd by registrar) ..... 1945

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... MarylandCounty ..... WashingtonCity or town ..... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... Locust Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... Aug 24 1945 at ..... 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her dead ..... Aug 24 1945 at ..... 10 A.M.  
on ..... Aug 24 1945 at ..... 10 A.M.Immediate cause of death ..... Heart DiseaseDURATION ..... 19 yrs.Due to ..... NoneDue to ..... NoneOther conditions ..... Decreasde was known to have had blues  
(Include pregnancy within 8 months of death)Major findings or operations ..... NoneDate of op. ..... NoneAutopsy results ..... cause of death unknown

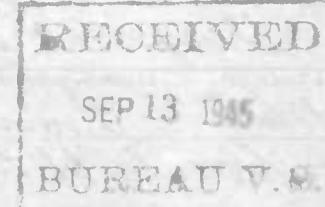
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... None Date of ..... NoneWhere did injury occur? ..... (City or town) ..... (County) ..... (State)Injured at home, farm, industry, public place (where?) ..... NoneMeans of injury ..... None Injured at work? ..... None23. SIGNATURE ..... P. W. Barr, Dep. Med. Ex. M. D. or otherAddress ..... Sept 11, 1945 Date signed ..... 9/11/45

STATE OF TEXAS VS. HARRY S. TRUMAN

DOCKET NO. 100



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16420

08064

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County.....  
City or town.....  
Walkersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
3 months

Hospital, institution, or street address where death occurred:

Fulton Ave.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Nellie R. Yessler

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

female

white

widowed

## 6. (b) Name of husband or wife

Harry Yessler

## 7. Birth date of deceased (mo., day, yr.)

February 13, 1874

## 8. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

71

6

15

hrs.

min.

## 9. Birthplace

Rocky Ridge, Fred. Co., Md.

(Town, county, and state)

## 10. Usual occupation

-

## 11. Industry or business

-

## FATHER

12. Name..... Daniel Edward Martin

## MOTHER

13. Birthplace..... Frederick Co., Md.

## MOTHER

14. Maiden name..... Sarah M. Crouse

## MOTHER

15. Birthplace..... Frederick Co., Md.

## 16. Informant

Miss Effie Martin

## Address

Philadelphia, Penna.

## 17. Burial

(Burial, cremation, or removal, which?)

Date thereof..... Aug. 31, 1945  
(month) (day) (year)

Cemetery or cemetery..... Creagerstown Cemetery

Location..... Creagerstown, Md.

## 18. Funeral director

Scott F. Minnich &amp; Son

## Address

Hagerstown, Md.

## 19. Aug. 29.

1945

Elizabeth G. Heels,  
Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Frederick

City or town..... Walkersville

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Fulton Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 28 1945 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her dead Aug 28 1945

Immediate cause of death.....

Hanging +  
Inhalation of chloroform

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Suicide Date of Aug. 28, 1945

Where did injury occur?..... Walkersville, Frederick, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Home

Means of injury..... Hanging + Chloroform Deputy

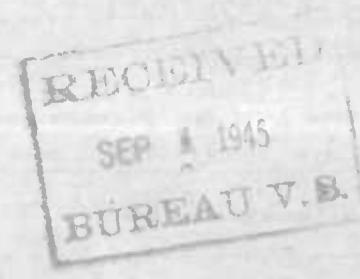
Injured at work? No

## 23. SIGNATURE

P. L. C. Barr M.D. Esq.

M. D. or other

Address..... Frederick, Md. Date signed..... Aug. 28, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08065

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

## 1. PLACE OF DEATH:

County FrederickCity or town State Sanatorium, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 5/7/45

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Since 5/7/45

## 3. (a) FULL NAME

Harry Young

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Male

White

Widower

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 11, 1904

## 8. AGE:

Years

Months

Days

If less than one day

41

3

29

hrs.

min.

## 9. Birthplace

Quarryville, Pa.

(Town, county, and state)

## 10. Usual occupation

Sheet metal worker

## 11. Industry or business

Harry Young

FATHER

## 12. Name

Pennsylvania

MOTHER

## 13. Birthplace

Georgia Ramsey

## 14. Maiden name

Pennsylvania

## 15. Birthplace

Daceased

## 16. Informant

Daceased

Address

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 8/13/45

(month) (day) (year)

Cemetery or location QuarryvilleLocation Quarryville, Lancaster Co., Pa.

## 18. Funeral director

S. L. Allison

Address

Emmitsburg, Md.

## 19. (Date rec'd by registrar)

8/18/45

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 38 S. Hanover St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

220-12-8653

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 9

19. 45 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 7 1945 to Aug. 9 1945

and that I last saw him alive on August 9 1945

Immediate cause of death

Pulmonary Tuberculosis

DURATION

5 Mos.20. Tuberculous Enteritis

1 Mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

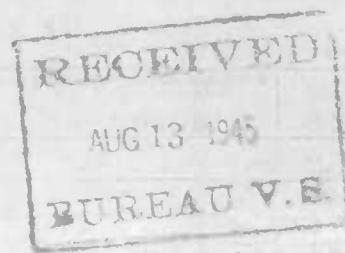
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. John YoungAddress State Sanatorium, Md. Date signed 8/10/45



M

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

## CERTIFICATE OF DEATH

08066

Reg. Dist. No.

144

## 1. PLACE OF DEATH:

County *Maryland*City or town *Thurmont - Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *50 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution? *7 days*

## 3. (a) FULL NAME

*Annie Belle Zeatly.*

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

*David G. Zeatly*

7. Birth date of deceased (mo., day, yr.)

*January 28, 1866*

8. (c) If alive, give age

years

8. AGE:

Years *79*Months *6*Days *10*

If less than one day

hrs. *.....*min. *.....*

9. Birthplace

*Emmitsburg, Frederick Co., Md.*

(Town, county, and state)

10. Usual occupation

*Housewife*

11. Industry or business

*Housewife*

12. Name

*William Martin*

13. Birthplace

*—*

14. Maiden name

*Elizabeth Steevey*

15. Birthplace

*—*

16. Informant

*William Zeatly*

Address

*Thurmont, Md. P.D.*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *Aug. 10, 1945*

(month) (day) (year)

Cemetery or crematory

*Holy Cross Cemetery*

Location

*Thurmont, Md.*

18. Funeral director

*M. L. George et al.*

Address

*Thurmont, Md.*

19. Aug. 9

1945

(Date rec'd by registrar)

Blanche L. Eley

Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Maryland*City or town *Thurmont - Md.*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *700*

(If rural, give LOCATION)

2. (a) If veteran, name war *WW II*

## 3. (b) Social Security Number

*None*

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Date *Aug. 8, 1945*at *3:30 A.M.*

1945

to *Aug. 8, 1945*

1945

and that I last saw her alive on *Aug. 7, 1945*

1945

DURATION

*10 days**10 days**10 days*

Immediate cause of death

*Cerebral Hemorrhage**10 days*

Due to

*Chronic Endocarditis**3 yrs*

Due to

*Chronic Arterial Scars**10 yrs*

Other conditions

*.....*

&lt;

RECEIVED

AUG 11 1945

BUREAU V.E.